The Senate met at 12 noon and was called to order by the President pro tempore (Mr. HATCH).

PRAYER
The Chaplain, Dr. Barry C. Black, offered the following prayer:
Let us pray.
Our Father in Heaven, we sing of Your steadfast love and proclaim Your faithfulness to all generations. Make us one Nation, truly wise, with righteousness exalting us in due season.

Today, inspire our lawmakers to walk in the light of Your countenance. Abide with them so that Your wisdom will influence each decision they make. Lord, keep them from evil so that they will not be brought to grief, enabling them to avoid the pitfalls that lead to ruin. Empower them to glorify You in all they say and do as You fill their hearts with thankful praise. May they never fail to acknowledge their total dependence upon You.

We pray in Your Holy Name. Amen.

PLEDGE OF ALLEGIANCE
The President pro tempore led the Pledge of Allegiance, as follows:
I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RECOGNITION OF THE MAJORITY LEADER
The President pro tempore. The majority leader is recognized.

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2018—MOTION TO PROCEED
Mr. McConnell. Mr. President, I move to proceed to Calendar No. 175, H.R. 2810.

The President pro tempore. The clerk will report the motion.

The bill clerk read as follows:
Motion to proceed to Calendar No. 175, H.R. 2810, a bill 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.

The President pro tempore. The majority leader.

WELCOMING BACK SENATOR MCCAIN
Mr. McConnell. Mr. President, I wish to start this morning with a few words about our friend and colleague from Arizona, Senator McCain, whom we will have an opportunity to welcome back today.

As I noted last week, we all know Senator McCain is a fighter. That is evidenced by his remarkable life of public service, just as it is again evidenced by his quick return to the Senate this afternoon. I know he is eager to get back to work, and we are all very pleased to have him back with us today.

HEALTHCARE
Mr. President, on the vote we will have today in a couple of hours, Senators will have an important decision to make. Seven years after ObamaCare was imposed on our country, we will vote on the critical first step to finally move beyond its failures.

Many of us have made commitments to our constituents to provide relief from this failed leftover experiment. Now we have a real opportunity to keep those commitments by voting to begin debate and ultimately to send smarter healthcare solutions to the President’s desk for his signature. Just yesterday, the President reiterated his intention to sign them.

Yesterday, the administration released a statement urging all Senators to vote in favor of the motion to proceed so that we can “move forward on repealing ObamaCare and replacing it with true reforms that expand choice and lower costs.” I wish to express my appreciation to the administration for its continued close work with us on this issue at every step of the way.

From the President and Vice President to Secretary Price and Administrator Verma, as well as others, the engagement we have seen has been important to our efforts, and it has sent an unmistakable signal to the country that this administration not only understands the pain middle-class families have felt under ObamaCare but is actually committed to doing something about it.

By now, we are all keenly aware of the pain ObamaCare has caused for literally millions of families. Premiums have skyrocketed, doubling on average in the vast majority of States on the Federal exchange. Insurance options have declined under ObamaCare, leaving many with as few as one or even zero insurers to choose from. Many Americans now face the real possibility of having no options at all and could find themselves trapped, forced by law to purchase ObamaCare insurance but left by ObamaCare without any means to do so. All the while, markets continue to collapse under ObamaCare in States across the country.

It is a troubling indication of what is to come unless we act. Fortunately, the American people have granted us the opportunity to do so. We finally have an administration that cares about those suffering under ObamaCare’s failures and a President who will sign a law to actually do something about it. We have a House that recently passed its own legislation to help address these problems. We have a Senate with a great chance before us to do our part now.

If other Senators agree and join me in voting yes on the motion to proceed, we can move one step closer to sending legislation to the President for his signature. I hope everyone will seize the moment. I certainly will. Only then can we open up a robust debate process.
Only then will Senators have the opportunity to offer additional ideas on healthcare.

Inaction will do nothing to solve ObamaCare's problems or bring relief to those who need it. In fact, it will make things worse for our constituents all across the country.

I wish to reiterate what the President said yesterday:

Any senator who votes against starting debate is telling America that you are (just) fine with the ObamaCare nightmare. . . .

That's a position that even Democrats have repudiated. Remember President Clinton called ObamaCare "the craziest thing in the world" and a Democratic Governor said it's "no longer affordable."

You won't hear me say this often, but they are right.

I hope colleagues will consider ObamaCare's history of failures—the unaffordable costs, the scarce choices, the burden on middle-class families—as they cast their vote this afternoon. I urge them to remember the families who are hurting under this collapsing law.

Numerous Kentuckians, like so many others across the Nation, have conveyed their heartbreaking stories with my office: one call after another, meetings, and dozens of healthcare forums all across Kentucky. These families are suffering under ObamaCare. They need relief. I will be thinking about them as I vote to proceed to the bill today.

I know for many other colleagues will do the same.

Our constituents are hurting under ObamaCare. They are counting on us. We may not get to conference in the House, the likely compromise is either a full repeal of the Affordable Care Act root and branch, a man who proselytized that Republicans should stop at nothing short of full repeal—why would the junior Senator from Kentucky vote to proceed knowing he will not get what he wants? It is because, I believe, he and some of the others in this body know that if the Senate manages to pass something to get to conference in the House, the likely compromise is either a full repeal of the Affordable Care Act or something close to it. It will certainly mean drastic cuts in Medicaid, huge tax cuts for the rich, no healthcare for those with preexisting conditions, and millions losing healthcare, particularly in our poorer and more brutal States. That is the only thing our Republicans have been able to agree on.

The hard-right Freedom Caucus in the House would never accept a Republican bill that only repeals a few regulations in the ACA but leaves much of it in place. No, they want full repeal, and, at minimum, deep cuts to Medicaid, huge tax breaks for the wealthy, and million more in this Nation losing their healthcare.

To my Republican friends who have repeatedly said that full repeal without replacement would be a disaster and to my Republican friends who have opposed the deep and drastic cuts to Medicaid, I say: Don't be fooled by this ruse. A vote in favor of the motion to proceed will mean deep cuts to Medicaid, maybe even deeper than in the House bill. It will mean people with preexisting conditions will be left high and dry. It will mean huge tax breaks for the wealthiest of Americans. It will mean millions will lose their coverage.

So with all the complaining, why are we here at this late moment? Because even the House bill was too drastic for many of the Members here, and it is now being ignored on this motion to proceed, and because we all know the ruse that is going on. The ruse is this: Send it back to the House; then, we will see what they send, and we will know what they will send. We may not know every detail. It will either be full repeal without replace or something far too close to that, and all of the work and all of the anguish that so many of my colleagues on the other side of the aisle have shown in the last several weeks will be wasted because they know darn well what is going to happen when there is a conference.

There are no Democratic votes in the House. The Freedom Caucus calls the shots. They will either ask for full repeal or something very close to it. Make no mistake about it. A vote in favor of the motion to proceed this afternoon will be a permission slip to slash Medicaid, hurt millions, and give huge tax cuts for the wealthy—something the vast majority of Americans in every State, a large percentage of Republicans and Trump voters, abhor.

One last plea to my colleagues: Do not fall for the ruse that the majority leader is putting together. We know what is going on. We all know. Our constituents will not be fooled—oh, no. We have seen the ruse before, and even if I hope my colleagues who, out of compassion and care for the people in their States, have made such a fuss up to now will not be fooled either.

Mr. President, in recent days, President Trump has gone out of his way to undermine his own Attorney General, his first supporter—what has been reported to be his best friend in the Senate. He has tweeted scathing criticism of Attorney General Sessions and chasised him publicly for recusing himself from the Russia investigation and several other perceived failures, in the eye of the President.

We should all take a moment to think of how shocking these comments are on a human basis. This is the first person who stuck his neck out for Donald Trump and who was with him throughout this and this Senate. He has tweeted scathing criticism of Attorney General Sessions and chasised him publicly for recusing himself from the Russia investigation and several other perceived failures, in the eye of the President.

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Second, I cannot imagine that my friends on the Republican side, particularly in the Republican leadership—my friend the majority leader, who I have great respect for, and Speaker Ryan—would be complicit in creating a constitutional crisis. They must work with us and not open the door to a constitutional crisis during the August recess.

Mr. President, on one last item, I know there is a lot going on today, but I just want to mention one item from the House of Representatives. Later, the House is going to take up and, hopefully, pass with near unanimity a sanctions bill that includes strong sanctions against Russia, Iran, and North Korea. It is critical that the Senate act promptly on this legislation.

I will work with the majority leader, as I have in recent weeks, to ensure its swift passage so we can get it to the President’s desk before we leave for recess. Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Nebraska.

Mrs. FISCHER. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

Mr. SCHUMER. Mr. President, I ask unanimous consent that the Democratic healthcare bill. Several months ago, I posed this question to the American people: How long before we run out of time? In the course of our time—one-sixth of the economy and tens of millions’ health and even lives affected without knowing exactly what we will be debating on. Perhaps nothing could sum up the process that has gotten us here as well as this. The best the majority leader has been able to cook up is a vague plan to do whatever it takes to pass something—anything—to get the bill to a House and Senate conference on healthcare. My colleagues, plain and simple, it is a ruse. The likeliest result of a conference between the House and Senate is the full repeal of the Affordable Care Act or something very close to it. It will, certainly, mean drastic cuts in Medicaid, Medicare, tax cuts for the wealthy, no help for those with pre-existing conditions, and tens of millions losing healthcare, particularly in poorer and more rural States.

The hard-right Freedom Caucus in the House would never accept a Republican bill that only repeals a few regulations in the ACA but leaves much in place.

I would say to my colleagues, particularly those on the other side of the aisle who fought hard for not cutting Medicaid drastically, for keeping preexisting conditions, for not giving tax cuts to the rich while you are cutting healthcare for the poor, do not go along with this motion to proceed, because you know and I know what it will lead to. All of the things that you have been trying to avoid will emerge from that conference, and you will hurt the people of your States dramatically.

We all know what is happening here. The leader could pretend the votes on a full repeal because it is so damaging to America. He could not get the votes even on his own bill. Instead, the plan is to come up with a proposal that is simply a means to repeal, a means to dramatic cuts, a means to getting us in conference, and we all know what the result of that conference will be.

I would plead one last time with my friends on the other side of the aisle—and I know you have sincerely tried to modify and change things—to turn back. We can go through regular order. We want to work with you. We know that the ACA is not perfect, but we also know that what you have proposed is much worse. We can work together to improve healthcare in this country. Turn back now before it is too late and millions and millions and millions of Americans are hurt so badly in ways from which they will never, ever recover.

I yield the floor.

The PRESIDING OFFICER. The majority leader.

Mr. MCCONNELL. Mr. President, 7 years ago, Democrats imposed Obamacare on our country. They said that costs would go down. Costs skyrocketed. They said that choice would curb. Choice plummeted. Now, Obamacare’s years-long lurch toward total collapse is nearing a seemingly inevitable conclusion, and it will hurt even more Americans on the way down.

This, my friends, is the Obamacare status quo. This is the status quo. We have had to accept it for a long time. We do not have to accept it any longer.

The American people elected a House with a vision of a better way on healthcare. Then they elected a Senate. Then they elected a President. Now, having been given the responsibility to govern, we have a duty to act. The President is ready with his pen. The House has passed legislation. Today, it is the Senate’s turn. That starts with a vote that we will take momentarily. The critical first step in that process is the motion to proceed. It is the vote that determines whether this debate can proceed at all, whether we even take up the four straight elections in which this was a huge commitment to the American people. It is the vote that determines whether the Senators of both parties can offer their amendments and ideas on healthcare.

I told the people of my State, over this period, that I would vote to move beyond Obamacare, and that is what I am going to do today by voting yes. I asked all of my colleagues to join me in doing so. We have shown that it is possible to put legislation on the President’s desk that moves us beyond Obamacare and its years of failure. We did that 2 years ago. President Obama vetoed what we passed before. President Trump will sign what Congress passes this time. I thank the President and the administration for all they have done on this issue already. They have worked with us every step of the way, and they, like us, know the consequences of failing to act.

Look, we cannot let this moment slip by. We cannot let it slip by. We have...
been talking about this for too long. We have wrestled with this issue. We have watched the consequences of the status quo. The people who sent us here expect us to begin this debate, to have the courage to tackle the tough issues. They did not send us here just to do the easy stuff. They expect us to tackle the big problems. Obviously, we cannot get an outcome if we do not start the debate, and that is what the motion to proceed is all about.

Many of us on this side of the aisle have waited for years for this opportunity and thought that it would probably never come. Some of us were a little surprised by the election last year, but with a surprise election comes great opportunities to do things that we thought were never possible. All we have to do today is to have the courage to begin the debate with an open amendment process and let the voting take us where it will.

That is what is before us, colleagues. Will we begin the debate on one of the most important issues confronting America today? It is my hope that the answer will be yes.

ORDER OF PROCEDURE

Mr. President, I ask unanimous consent that, following the vote, Senator McCain be recognized to speak for the duration of the session. Without objection, it is so ordered.

AMERICAN HEALTH CARE ACT OF 2017—MOTION TO PROCEED

Mr. MCCONNELL. Mr. President, I move to proceed to Calendar No. 120, H.R. 1628.

The PRESIDING OFFICER. Without objection, it is so ordered.

[Role Call Vote No. 167 Leg.]

YEAS—50

Baldwin
Bennet
Blumenthal
Booker
Brown
Cantwell
Cardin
Carper
Casey
Collins
Connors
Cortez Masto
Donnelly
Duckworth
Durbin
Feinstein
Franken

NAYS—50

Alexander
Barrasso
Blunt
Boozman
Burr
Capito
Cassidy
Cochran
Cruz
Daines
Enzi
Ernst
Fischer

Perdue
Portman
Risch
Roberts
Round
Rubio
Sasse
Scott
Shelby
Strange
Sullivan
Thune
Tillis
Toomey
Wicker
Young

The VICE PRESIDENT. As a reminder to our guests, expressions of approval or disapproval are not permitted.

On this vote, the yeas are 50, the nays are 50. The Senate being equally divided, the Vice President votes in the affirmative.

The motion is agreed to.

AMERICAN HEALTH CARE ACT OF 2017

The VICE PRESIDENT. The clerk will report the bill.

The legislative clerk read as follows:

A bill (H.R. 1628) to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017.

The VICE PRESIDENT. The senior Senator from Arizona is recognized.

ROLE OF THE SENATE

Mr. MCCAIN. Mr. President, I have stood in this place many times and addressed as “President” many Presiding Officers. I have been so addressed when I have sat in that chair, and that is as close as I will ever be to a Presidency. It is an honorific we are almost indifferent too; isn’t it? In truth, presiding over the Senate can be a nuisance, a bit of a ceremonial børe, and it is usually relegated to the more junior Members of the majority.

But as I stand here today—looking a little worse for wear, I am sure—I have a refreshed appreciation for the protocols and customs of this body and for the other 99 privileged souls who have been elected to this Senate.

I have been a Member of the U.S. Senate for 30 years. I had another long, if not as long, career before I arrived here, another profession that was profoundly rewarding and in which I had experiences and friendships that I revere. Make no mistake, my service here is the most important job I have ever held. I am so grateful to the people of Arizona for the privilege—for the honor—of serving here and the opportunities it gives me to play a small role in the history of the country I love.

I have known and admired men and women in the Senate who played much more than a small role in our history—true statesmen, giants of American politics. They came from both parties and from various walks of life. Their ambitions were frequently in conflict. They held different views on the issues of the day. They often had very serious disagreements about how best to serve the national interest.

But they knew that however sharp and heartfelt their disputes and however keen their ambitions, they had an obligation to work collaboratively to ensure the Senate discharged its constitutional responsibilities effectively. Our responsibilities are important—vital responsibility for the constitution and the success of our Republic. Our arcane rules and customs are deliberately intended to require broad cooperation to function well at all. The most revered Members of this institution accepted the necessity of compromise in order to make incremental progress on solving America’s problems and to defend her against her adversaries.

That principled mindset and the service of our predecessors who possessed it come to mind when I hear the Senate referred to as the world’s greatest deliberative body. I am not sure we can claim that distinction with a straight face today. I am sure it wasn’t always deserved in previous eras either. I am sure there have been times when it was, and I was privileged to witness some of those occasions.

Our deliberations today, not just our debates but the exercise of all our responsibilities—authorizing government policies, appropriating the funds to implement them, exercising our advice and consent role—are often lively and interesting. They can be sincere and principled, but they are more partisan, more tribal more of the time than at any other time in my memory. Our deliberations can still be important and useful, but I think we would all agree they haven’t been overburdened by greatness lately. Right now, they aren’t producing much for the American people.

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our enemies from doing their worst aren’t glamorous or exciting. It doesn’t feel like a political triumph. It is usually the most we can expect from our system of government, operating in a country as diverse, quarrelsome, and free as ours.

Considering the injustice and cruelties inflicted by autocratic governments and how corruptible human nature can be, the problem-solving our system does make possible, the fitful progress it produces, and the liberty and justice it preserves, are a magnificently

Our system doesn’t depend on our nobility. It accounts for our imperfections and gives an order to our individual strivings that has helped make ours the most powerful and prosperous society on Earth. It is our responsibility to preserve that, even when it requires us to do something less satisfying than winning, even when we must give a little to get a little, even when our end just 3 yards from the goal line is a cloud of dust, while critics on both sides denounced us for timidity, for our failure to triumph.

I hope we can again rely on humility, on our need to cooperate, on our dependence on each other and on trust each other again and, by so doing, better serve the people who elected us. Let’s stop listening to the bombastic loudmouths on the radio, television and the internet. To hell with them. They don’t want anything done for the public good. Our incapacity is their livelihood.

Let’s trust each other. Let’s return to regular order. We have been spinning our wheels on too many important issues because we keep trying to find a way to win without help from across the aisle. That is an approach that has been employed by both sides: mandating legislation from the top down, without any support from the other side, with all the parliamentary maneuvers it requires. We are getting nothing done, my friends. We are getting nothing done.

All we have really done this year is confirm Neil Gorsuch to the Supreme Court. Our healthcare insurance system is a mess. We all know it, those who support ObamaCare and those who oppose it. Something has to be done. We Republicans have looked for a way to end it and replace it with something better. We have tried to do this by coming up with a proposal behind closed doors in consultation with the administration, then springing it on skeptical Members, trying to convince them it is better than nothing—that it is better than doing nothing. And now our doubts and force it past a unified opposition. I don’t think that is going to work in the end and probably shouldn’t.

The administration and congressional Democrats shouldn’t have forced through Congress, without any opposition support, a social and economic change as massive as ObamaCare, and we shouldn’t do the same with ours. Why don’t we try thedialog way of legislating in the Senate—the way our rules and customs encourage us to act. If this process ends in failure, which seems likely, then let’s return to regular order. Let the Health, Education, Licensing and Pennywise agreement, under Chairman ALEXANDER and Ranking Member MURRAY, hold hearings, try to report a bill out of committee with contributions from both sides—something that none on the other side of the aisle didn’t allow to happen 9 years ago. Let’s see if we can pass something that will be imperfect, full of compromises, and not very pleasing to implacable partisans on either side but that might provide workable solutions to problems Americans are struggling with today.

What have we to lose by trying to work together to find those solutions? We are not getting much done apart. Why don’t we try the dialog way of legislating in the Senate—the way our rules and customs encourage us to act. If this process ends in failure, which seems likely, then let’s return to regular order. Let the Health, Education, Licensing and Pennywise agreement, under Chairman ALEXANDER and Ranking Member MURRAY, hold hearings, try to report a bill out of committee with contributions from both sides—something that none on the other side of the aisle didn’t allow to happen 9 years ago. Let’s see if we can pass something that will be imperfect, full of compromises, and not very pleasing to implacable partisans on either side but that might provide workable solutions to problems Americans are struggling with today.

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The majority leader.

**AMENDMENT NO. 267**

(Purpose: Of a perfecting nature.)

Mr. MCCONNELL. Mr. President, I call up amendment No. 267.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

> The Senator from Kentucky [Mr. MCCONNELL] proposes an amendment numbered 267.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

Mrs. MURRAY. Mr. President, I object.

The PRESIDING OFFICER. Objection is heard.

The legislative clerk continued with the reading of the amendment.

(Disturbance in the Visitors' Galleries.)

The PRESIDING OFFICER. The Sergeant at Arms will restore order in the Gallery.

(Disturbance in the Visitors' Galleries.)

The PRESIDING OFFICER (Mr. STRANGE). The Sergeant at Arms will restore order in the Gallery.

The clerk will continue.

The legislative clerk continued with the reading of the amendment.

(The amendment is printed in today's RECORD under "Text of Amendments.")

The PRESIDING OFFICER. Who yields time?

If no one yields time, time will be charged equally.

The Senator from Wyoming.

Mr. ENZI. Mr. President, I ask unanimous consent that, for the duration of the Senate's consideration of H.R. 1628, the majority and Democratic managers of the bill, while seated or standing at the managers' desks, be permitted to deliver floor remarks, retrieve, review, and edit documents and send email and other data communications from text displayed on wireless personal digital assistant devices and tablet devices.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ENZI. Mr. President, I ask unanimous consent that the use of calculators be permitted on the floor during the consideration of H.R. 1628.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ENZI. Mr. President, what is the regular order with respect to the pending amendment?

The PRESIDING OFFICER. It is 2 hours equally divided.

Mr. ENZI. Thank you, Mr. President. I suggest the absence of a quorum and ask unanimous consent that the time be equally divided.

The PRESIDING OFFICER. Is there objection?

Mrs. MURRAY. Objection.

The PRESIDING OFFICER. Objection is heard.

Mr. ENZI. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. NELSON. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

WELCOMING BACK SENATOR MCCAIN

Mr. NELSON. Mr. President, I am so encouraged by the words of our dear friend and fellow Senator, Mr. JOHN MCCAIN.

First of all, I am so encouraged by seeing that fighting spirit of JOHN MCCAIN and so glad to see him back. In the midst of everything he is facing, he would come and insert himself to give us some considerable words of wisdom—it was such an enormous, emotional experience when JOHN walked in. Then, to have all of us seat ed here because of the vote that was occurring—and not a Senator left after the vote was concluded because we occurred—and not a Senator left after the vote was concluded because we were seeing that fighting spirit of JOHN.

Mr. President, this Senator never thought we would see a vote to advance a bill which, to so many, feels as though it is going to harm so many of our fellow Americans. Obviously, we can disagree on specifics, but we have seen that particular expression of opinion of harm over and over. We have seen it in the coverage of the townhall meetings, where people stand up and say: If I didn't have this healthcare, I would be dead.

This Senator has seen it in Florida over and over, as I have had people come up to me where I am—in a meeting, on the street corner, in the airport, wherever—and say: Senator, please don’t let them take my healthcare away from me.

Indeed, when people explained their particular circumstances, four different stories, if they did not have the waiver on Medicaid, indeed, that fellow would not only not be alive, but even if he were alive, he would be in an institution instead of being able to be cared for or three other families who brought forth testimonies about how the Affordable Care Act has given them insurance they had never been able to get before. It was at a price they could afford and involved coverage they never could have had.

In other words, they had preexisting conditions. This Senator, as a former elected insurance commissioner of Florida, has seen insurance companies refuse to insure people because they had a preexisting condition. If you had a preexisting condition; if you had a bad rash, that was a preexisting condition, and they were not going to insure you. Also, insurance policies never had the guarantee whether it is a Medicaid type of insurance or whether it is an actual policy through a private insurance company offered on the health exchanges in the States or whether it is the guarantees of the coverage in an individual policy that they might buy, they just want healthcare. That is the reason you have health insurance in the first place.

Now, I have heard some fixes say: Oh, let’s cut back on Medicaid, which, remember, is spread over millions of people, just like Medicare is spread over millions and millions of people. The difference there is age. If you are 65, you are eligible for Medicare.

There are some people we overlook in the system who depend on Medicaid. How about veterans? Veterans’ healthcare has been taken care of while on Active Duty in the U.S. military. Then their healthcare is transferred to the Veterans’ Administration, but there are a lot of veterans who are not getting their healthcare through the VA. They get their healthcare through Medicaid. If you start cutting back on Medicaid, which are the versions of the so-called replace bills we have seen—if you start cutting back on Medicaid and make a capped program or a block grant program, we already know the figures. It has been costed out by the CBO. The figures tell us it is close to an $800 billion cut over a decade. When you start doing that, the people who rely on Medicaid at the edges, like some poor people or like seniors in nursing homes—by the way, in my

If we are really serious about wanting to fix the situation, if our brothers and sisters on the other side of the aisle are not successful in proceeding with what the majority leader is going to be coming forth with, if that is voted down, and if we are serious about it, what is the existing law—the Affordable Care Act—and fix it.

Senator COLLINS, a former insurance commissioner, appointed in the State of Florida, the Senator—a former elected insurance commissioner in the State of Florida, are already working on a reinsurance fund which would ensure the insurance companies against catastrophe. I asked for this to be costed out in the State of Florida. This fix would lower premiums 13 percent in the State of Florida.

In the words of Senator MCCAIN, if we really want to get together and fix the problems, we can. Yet, in the midst of hearing from constituents all around the country who have shared their personal stories about how the existing law has helped, we are in the parliamentary position we are in, where we will proceed on trying to repeal what is the existing law.

For some people, they don’t care about the politics. As a matter of fact, for a lot of people, they don’t care about the politics. They just want access to healthcare. They want what is genuinely described as health insurance, whether it is a Medicaid type of insurance or whether it is an actual policy through a private insurance company offered on the health exchanges in the States or whether it is the guarantees of the coverage in an individual policy that they might buy, they just want healthcare. That is the reason you have health insurance in the first place.

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State, 65 to 70 percent of the seniors in nursing homes are on Medicaid, and some of those veterans I told you about are not on VA healthcare but Medicaid. How about some of the children’s programs on Medicaid? If you start cutting that back to the tune of an $800 billion dollar loss, you’re going to knock out a lot of these people. That is not something we want to do. That is why, when explained, you have such low numbers who support what is being attempted as a replacement if you repeal the Affordable Care Act. It should be focused on working together to improve the Affordable Care Act, not to make it worse.

I pretty much have said it all. The bills we have seen coming forth as replacements change the age ratio from the existing law, the Affordable Care Act, of 3 to 1 in the healthcare exchanges so you can charge an older person three times as much as a young, healthy individual—not in the replacement that is coming up. It is not 1. What does that mean? That means for those older Americans, before they turn 65 and become eligible for Medicare, they are going to be paying more for their insurance premiums. Is that what you want to do? I don’t think so. You cannot ignore these facts. I ask those who come forth with these replacements, why in the world do you do this? Why do you support a bill that will hurt so many Americans, which has been demonstrated over and over. Why do you support a bill that will hurt so many of your constituents that your constituents cry out to you, please, don’t do this? And they give personal testimonies.

I urge our colleagues, after the emotional appeal of Senator McCain, to do things in a bipartisan way. Take a moment, reflect on what your constituents have said—not just some of your constituents. Listen to all of your constituents and ask yourself, are you doing the right thing? Let’s improve our Nation’s healthcare system. Let’s not make it worse. Let’s do it in the spirit of the uplifting words of Senator McCain and what he said: Let’s do it together in a bipartisan way.

I yield the floor.

Mr. Hatch. Mr. President, I rise today to once again remind my Senate colleagues what is at stake with the procedural vote that took place today. That Senate is on the motion to proceed to the House-passed budget reconciliation bill. The Senate will now start working in earnest to consider and, hopefully, pass legislation that will repeal and replace the Affordable Care Act with a 2-year transition period, or other, specific replacement policies.

That is a complicated undertaking to say the least. However, the first vote on the procedural vote was relatively simple. While pundits and talking heads have already analyzed this particular vote to death, all of the talk boils down to a single question: Do Republican senators want to repeal and replace ObamaCare?

I don’t want to belittle or discredit the concerns some of my colleagues have raised about the various legislative proposals that are out there. However, we were voting on any particular policy or proposal.

On the contrary, the vote was simply to determine whether the Senate is actually going to consider the budget reconciliation bill. Members were not voting for or against any particular healthcare proposal; they were simply voting on whether the Senate will actually debate any such measure.

That being the case, the vote was a simple one. Anyone who supports the larger effort to repeal and replace ObamaCare should be willing to at least debate the various proposals that have been put forward.

That is the very definition of a no-brainer.

The essential pieces of ObamaCare were signed into law in March 2010, more than 7 years ago. Since then, the law has been one of the key focal points of legislative and political debate and discourse nationwide. Very few topics in our Nation’s history have been the subject of more public debate and fierce disagreement.

After all this time, one thing is very clear: ObamaCare has failed the American people.

The vast majority of Americans are dissatisfied with the healthcare status quo. These people want answers from Congress that will bring down their healthcare costs, reduce their tax burdens, and put them back in charge of their own healthcare. For more than 7 years now, virtually every Republican in Congress has been promising to provide those solutions.

We have never been closer to making good on those promises than we are right now with a Republican President and Senate ready to support congressional efforts to repeal and replace this unworkable law.

Make no mistake, none of the major proposals that have been put forward are perfect. In fact, in my personal view, they are all far from perfect. But, at the end of the day, any bill—particularly a bill as wide and sweeping as one that addresses a large portion of our healthcare system—that is “perfect” in the eyes of one Senator is likely fatally flawed in the eyes of 99 others.

Translation: When it comes to legislating successfully, the word “perfect” shouldn’t be in anyone’s vocabulary.

Like any aspect of governing, drafting and passing important legislation is about compromise and prioritization. It is about recognizing which fights need to be fought now and which ones can wait for another day.

I have been here a while. In that time, I have noticed a few things. Some senators in the Senate Chamber would rather fight the good ideological fight for legislative purity than get the majority of what they want—but not everything—through compromise. These people tend to claim that even the most embarrassing legislative losses are victories, so long as they can say that they went down swinging.

Now, don’t get me wrong; speaking in terms of advocating good policy I have never been seen as an appeaser from a fight. In fact, I have battled some of the most revered and admired Senators in our Nation’s history right here on the Senate floor.

One reason I think I have developed a reputation as an effective legislator is I don’t believe that fighting for a cause is an end unto itself. Fights are only meaningful if there is an objective in mind. While I am no mathematician, I believe getting 60, 70, or 80 percent of what you want out of a bill is better than getting nothing, even if, on the way to getting nothing, you have fought a valiant fight for that perfect—yet ultimately unattainable—outcome.

The fight to repeal ObamaCare, at least from where I have been standing, has always had an objective in mind. That objective, of course, has been to actually repeal ObamaCare.

We have fought for that objective for more than 7 years. Now, we must convince the American people that we can make good on our promise. If we take major steps toward that larger goal.

No, we don’t have a perfect bill to vote on. However, the fact remains that we are close to being able to pass legislation that would accomplish the majority of our goals and keep most of the promises we have made to our constituents.

Before we can do any of that, we need to at least get a chance to consider and debate the matter on the floor. That is what this afternoon’s vote was to determine: whether we are committed enough to this effort to at least take that step.

I remind my Republican colleagues that, when the ObamaCare reconciliation bill was brought up for debate in 2010, all of our friends on the other side, who were present at the time, except for one Member, voted in favor of the motion to proceed. They supported their leader. Leader McConnell is owed the same loyalty.

Any Senator who has fought with us to undo the damage caused by ObamaCare should be willing, at the very, very least, to take that step and allow the floor debate to actually happen.

I hope we all will. Toward that end, I urged my colleagues to vote in favor of the motion to proceed to the House-passed reconciliation bill to allow the Senate to begin debate on repealing and replacing ObamaCare.

Presiding Officer. Who yields time?

If no one yields time, time will be charged equally to both sides.

The Presiding Officer. The as- signed Democratic leader.

Mr. Durbin. Thank you, Mr. President.

History was made on the floor of the Senate Chamber today. I don’t think it
has ever happened before. Think about this: 50 out of 100 Senators came to the floor with the Vice President of the United States and voted to begin debate on a bill they have never seen—a bill they have never seen—because we don’t know what the Republicans are going to offer as the alternative to the Affordable Care Act.

There have been a lot of different versions. Technically, the one that is before us now is the version that passed out of Representatives, but I think the Republican leader, Senator MCCONNELL, has known from the beginning that there is no chance whatsoever. So many Republicans have taken a look at what the House passed and said: We can’t vote for that. You have to give us something different. The problem the Senate Republicans ran into is that they couldn’t come up with anything better.

They tried. They wrote several different versions, and every time they wrote a version of the new Affordable Care Act, it got worse for the American people, and here is what I mean. Under one proposal for the Republicans—not the one before us, but the Senate Republicans—1 million people in the state of Illinois would have lost their health insurance. There are 12.5 million people in Illinois, and 1 million would have lost their health insurance because of dramatic cutbacks in Medicaid and cutbacks in the premium support that is given to a lot of working families to buy regular health insurance in the health insurance market.

It was so terrible that every time Republicans came up with a Senate proposal, two or two of them would announce: Can’t buy it, won’t vote for it—and ran away from it.

So Senator MCCONNELL came to the floor today and said: I am begging you, just vote to open debate on a bill that I have written, and 50 Republican Senators did, and the Vice President broke the tie, the 50-to-50 tie to allow the Vice President to break the tie, as Senator MCCONNELL said. We have gone back and forth through all the provisions on immigration. John even conceded today that he has an interesting temperament. There were days when John McCaïn was Mount Vesuvius, just exploding in every direction, and you had to step back. And there were days when he smothered you with kindness.

That is the way he is. We love him for it.

He came today to give a speech that every American should read if you want to understand how a Democratic Senator can stand on the floor and give compliments and praise to a Republican Senator, which I am about to do. Senator McCaïn said that we have to do something here beyond policy of ours—the political divisions. I will not get the words perfectly, but he said to us: You will please start ignoring these radio and TV and Internet talking heads who want us to fail and make a living by laughing at us. Will you join us in fighting for more those people? Instead, look to what this institution, the U.S. Senate, is all about and what we should be doing to solve the problems for the people we represent.

John McCaïn went on to say: Why don’t we have debates on the floor of the Senate anymore? Do you know what? He is right. We are 7 months into this year’s Senate session. We have not had one bill on the floor of the Senate that we have debated and amended—not one. This is a first, and it is in this kind of convoluted reconciliation process where you speed up the amendments.

Think about this. We are amending your healthcare policy that affects you and your family. We are amending how you will buy health insurance as an individual and how your company will buy health insurance for you. We are amending, basically, whether your insurance policy is going to protect your family or not, and how it works.

People propose an amendment, and then we debate it. Do you know how long we debate it? We debate it for 1 minute on both sides. Disgraceful. John McCaïn called us on it today and asked: Why do we reach this point when an issue this important is going through a process that is totally partisan?

You see, the Republicans decided early on that they were not going to invite us to the party; that they were going to write this healthcare bill by themselves, in secret. Senator McCaïn picked 13 Republican Senators, and they sat for 10 months—long—months, weeks, and wrote a bill. One of them I mentioned earlier was ultimately rejected by the Republicans themselves. John McCaïn challenged us and said: For goodness’ sake, he has not seen in the Senate in the last 5 months that I have too—things that I have seen in the Senate when I was much different. He really begged us, pleaded, and urged us to get back to that time when we worked together on a bipartisan basis to solve problems. John McCaïn was right. I did not agree with him, and I voted to put us in that. But I was encouraged by the way he closed. He turned to Senator McCaïn, who was sitting right there, and said to him: Do not count on my vote on final passage. I want to see what we do in this bill. I want to see how we debate this bill.

One Republican Senator like John McCaïn can make the difference as to whether this process stops and a real honest process begins. Isn’t that what the American people expect of us?

Seated in the Chair, the Presiding Officer, is a brand new Senator from the State of Alabama.

Welcome, Senator Strange... He took his name. Senator Sessions went on to become the Attorney General. He has seen the Senate for a couple of months or 3 months, maybe—5 months now—and I am sure he has his impressions of this body. They may be different than the ones we thought about it before he was elected. Yet I can tell him for sure that this is a much different Senate than the one Patty Murray was elected to, that it is much different than the one I was elected to. Even for Mike Enzi, my friend from Wyoming, it is much different than the one he saw.

I see my colleague here, Senator Schatz, from Hawaii.

How long have you been here now, Brian?

Mr. Schatz. Four-and-a-half years.

Mr. Durbin. Four-and-a-half years. He is a newbie, and he has not seen the Senate I am describing.

Can you believe there was a time in the Senate when we would bring an important measure to the floor on many different issues, and Members would come to the floor—I am not making this up—and actually hand an amendment to the clerk and say: I would like to offer this amendment to this bill. Then we would debate it, and then we would vote on it. Sometimes you won, sometimes you lost, and you moved on to the next amendment. That actually happened on the Senate floor. For the people who are not new to the Senate, I am sure you do not believe me. It did happen over and over and over. We had a healthy respect for one another. The amendments went back and forth, and we ended up seeing bills passed that made a difference in America.

What we are doing now is a disgrace to this institution, and it does not honor the Senate, its Members, or our Constitution when what is at stake is
so important. In looking at some of the provisions that have been brought before us in the Senate’s Republican repeal bills to repeal the Affordable Care Act, I do not know how they can do it. I do not know how Senators could go home and say in their home States: A million people are going to lose your health insurance because of something I just voted for.

Health insurance means a lot to me personally. I have said it on the floor. There have been times in my life when I was a brand new law student and was married. God sent me and my wife this beautiful little baby. She had some health issues, and we had no health insurance, as I was a law student. We ended up sitting in the charity ward of a local hospital here in Washington, hoping our baby girl would have a good, talented, capable doctor walk through the door and see her. I was not sure because I did not have health insurance. I will never forget that as long as I live, and I thought to myself that it will never happen to me again. I am going to have health insurance no matter what it takes. It meant that much to me, and it means that much to everybody.

There is not a single one of us who does not want the peace of mind of knowing that if we get sick or if someone we love gets sick, he will have access to good hospitals and good doctors. That is what health insurance is all about. As the Republican proposals eliminate health insurance for 60 million, 20 million, 30 million Americans, you ask yourself: How can you do that to this country?

The cuts they make in Medicaid have really educated America about Medicaid. People know about Social Security. They know that what is all about. We all pay into it and wait to receive our Social Security checks when we reach that age. They also know about Medicare. We have to be 65 to qualify for that age. It is pretty good coverage, isn’t it? The ones who receive it think it is a pretty good deal to have Medicare coverage when they reach the age of 65, but Medicaid was one of those mystery programs. People were not sure. What does it do? The Medicaid Program in America does the following:

In Illinois, that program takes care of half of the new mothers and their babies. Half of them are paid for by Medicaid. To make sure the baby is healthy, the delivery of the baby. Afterward, the mom and baby are taken care of, paid for by Medicaid. This is one out of every two births in Illinois.

Medicaid also sends provisions—money—to your local school districts. I will bet you did not know that. If your local school district has a special education program—and virtually all of them do—they receive Medicaid to pay for some basics. It pays for counselors for special ed students. Sometimes transportation in a local school district in downstate Illinois or feeding tubes for some severely disabled students are paid for by Medicaid. You may not know that for disabled people, Medicaid is their health insurance. Many of them have no place else to turn.

I mentioned on the floor before that a mother in Champaign, IL, with an autistic child, said: Senator, if it were not for Medicaid, my son would have to go into an institution. I couldn’t afford it.

Medicaid is his health insurance.

I have not touched the most expensive part of Medicaid of which you may not know, which is that two out of three people in nursing homes depend on Medicaid to get basic medical care. Medicare is not enough. They need the help of Medicaid. So if it is Mom or Dad or Grandma or Grandpa who is in a nursing home, two out of three of them depend on Medicaid.

The Republican bill to replace the Affordable Care Act says we are going to cut Medicaid, that 25 to 35 percent will be cut. That is why Governors of both political parties have screamed bloody murder: You cannot do that. You are cutting the Federal contribution to Medicaid in our States. Who is going to pay for that? Who is going to pay for the disabled? Who is going to pay the school district? Who is going to pay the disabled? Who will take care of the disabled? Who will take care of the folks in nursing homes?

Why did they make such deep cuts in Medicaid if that is so important to so many people? There is the tough part. That deep of a cut was made in Medicaid so Republicans, in their healthcare proposal, could include a tax break for the wealthiest people in America, for health insurance companies, and—get this—for pharmaceutical companies. To give them tax breaks, they had to cut Medicaid coverage for all of the people whom I just described. Is it any wonder that many Republicans backed away from this? Senator HELLER, of Nevada, talked to Governor Sandoval—both Republicans—and said he could not support an early version of the bill because of the deep cuts in Medicaid.

If this is supposed to be an improvement over the Affordable Care Act, which part of it is an improvement? Is it in cutting Medicaid coverage for all of those people, saying that your health insurance company does not have to cover people with preexisting conditions, raising the cost of healthcare premiums, particularly for people between the ages of 50 and 64, eliminating health insurance for millions? Is that an improvement over the current system? It is not. It is a disaster.

The question is, By the end of this debate, after we have gone through this crazy process of voting up and down quickly and with very little debate, will our more Republican Senator from Ohio, vote up and approve? Two of them have. If one more will join them, then we can get down to the real business we should face. The real business is being the Senate again with regular order, which means taking the measure to the HELP Committee. Senator MUR- RAY, of Washington, is the ranking Democrat. Senator LAMAR ALEXANDER is the chairman from Tennessee. I respect him and like him a lot. The two of them fought for a bill to change the affordable care system and make it work better, bring down the cost of premiums, and expand health insurance coverage. I think that is what we should be all about. It is not a change in philosophy here. I will close with this, but this is what drives us. Answer the following question, and I can tell you how you are going to vote on this bill:

Do you believe healthcare is a right for every American or do you believe it is a privilege; that if you have enough money and you are lucky enough, you can get it, and if you don’t, you go without.

If you answer the question that it is a right, that it should be a right in America, then you have to reject this approach. You cannot take helpless people, some of whom are working hard in two and three jobs at a time and who have no healthcare benefits, and say to them: Sorry. Our system will not take care of you.

One last point. The irony of that is that if you do not give people health insurance, if you do not give them protection, they still get sick, they still go to the hospital, and they still get care. What happens to the bills they cannot pay? Everybody else pays them. Before the Affordable Care Act, each of us paid $1,000 a year in premiums just to cover for the people who could not afford health insurance.

We think there is a better way. We think Americans should have access to affordable health insurance across the board, and we think we can achieve that if we work together on a bipartisan basis. So I hope the more Republican Senator will join Senators COLLINS and MURKOWSKI and bring us back to what JOHN MCCAIN described on the floor today to the Senate—of having a real debate about real issues and really caring about the American people. I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. BROWN. Mr. President, I ask unanimous consent that after my re- taker from Ohio.

Mr. BROWN. Mr. President, I ask unanimous consent that after my re-
the voting public in their districts and their States. All of them have health insurance that is paid for by the taxpayers, and they would vote to take insurance away from hundreds of thousands of people in my State and in Washington and in Wyoming and in Alabama and in Hawaii.

Millions of people around the country, most of whom have jobs—people who are working $8-, $10-, $12-, $15-an-hour jobs—are not as well paid as the staff. We stand behind us as these floor sessions go on, and they would take insurance away from people like them. I am still just incredulous that that would have happened. This bill affects all of our constituents. It would upend one-fifth of the American economy. Yet the people whom we serve have no idea what is in this bill. We really do not know what is in it.

Over the weekend, people said Senator MCCONNELL was going to bring us all to the floor on Tuesday to vote on the healthcare bill. This is the law. As the floor leader, I talk about those options. Thebicameral Budget Office, 18 million Americans will lose their health insurance next year, and premiums will go up 20 percent. Professionals hold these jobs. They are people who are not Republicans, who are not Democrats, who are just like the Parliamentary, who is not aligned with either party. The Congressional Budget Office is just like that.

Again, think about that. Think of the Members of the Senate. Think of the Senate’s staff who line up along this wall during floor sessions. All of us have to go down there and take it away. According to this plan behind door No. 1, we are going to take it away from 18 million Americans. There would be less coverage, and premiums would go up 20 percent—higher costs. By the end of this decade, 32 million Americans—that is like 1 out of 10 Americans—who currently have insurance would be without health coverage and premiums would double. So 32 million people lose their insurance within the decade and premiums double.

Let’s talk about Barbara, whom I met in Toledo just recently, is 63. She is not old enough for Medicare; she relies on the healthcare exchanges. Repeal with no replacement would create massive uncertainty for Ohioans. Their Senator, who voted yes today—does the Senate staff who stands behind here who have insurance from—taxpayers like Barbara—do they think about Barbara? Do they think about somebody who reads in the paper that the Senate took the first—still reversible but barely—step toward taking their insurance away? Do they ever think about people like Barbara? Do they, as President Lincoln said, ever get out and get their public opinion pass and listen to people like Barbara? She is 63 years old, and she doesn’t know if she will have insurance next month. Imagine that. Do the staff back here, do the Senators who get insurance from taxpayers—do they think: Oh, maybe my insurance won’t exist a few months from now. Do they think about that? I am guessing they don’t.

Repeal with no replacement creates massive uncertainty for Ohioans like her. We have already seen this year what that uncertainty does to Ohio families, with insurance companies that have been forced to pull out of the market as Congress and the White House create more and more uncertainty. When Aetna pulled out of Dayton and other communities in Ohio—in that town Ohioans and others left nearly 20 counties in Ohio without any insurer next year. When they did that, they announced it was because of the uncertainty in this Congress, that nobody really quite knows what is happening.

So that is door No. 1—repeal with no replacement, higher cost, less coverage.

Let’s look at door No. 2. Behind door No. 2 is the plan that MITCH MCCONNELL negotiated in secret. As I said, straight down this hall, go to the right, that is MITCH MCCONNELL’s office. That is where the drug company lobbyists hung out; that is where the insurance company lobbyists hung out; that is where the Wall Street lobbyists hung out and a small number of Senators, and then they slammed the door shut. That is how they wrote this bill. The Presiding Officer left from his constituents in Florida. The drug companies wrote the bill. The insurance companies wrote the bill. Wall Street wrote the bill. And, alas, the bill: tax cuts for insurance companies and tax the drug companies. The 400 richest families in America will get—under this McConnell door No. 2, there are not just higher costs with less coverage for the public, but 400 families will average a $7 million tax cut for each of the next 10 years.

The McConnell plan would increase healthcare costs for working families. We know that. They would slap on higher costs. They would slap on taxes on Ohioans over 50 when they buy insurance. And when it comes to healthcare costs, Senator HELLER from Nevada said it best: There is nothing in this bill that would lower premiums. They give tax breaks to the insurance companies and tax other people. They give tax breaks to the insurance and the drug companies. They cut Medicaid. But there is nothing in this bill, according to Senator HELLER, a Republican from Nevada, that would lower premiums. There are, however, those massive tax breaks for drug companies that have been jacking up prices on lifesaving medicines like insulin and those drug companies that played a role in creating the opioid epidemic that devastates my State. More people in my State—as the Presiding Officer, who also represents a large State, knows—more people in my State died of opioid overdose than any other State in the United States.

What does this plan do for the opioid epidemic? I have had dozens—maybe not dozens—I have done at least 15 or 20 roundtables around Ohio to talk about the opioid epidemic with doctors and counselors and psychologists and therapists and nurses, people who are recovering from addiction and their families, and others. One thing they all agree on is that the single best tool to combat the opioid addiction is, alas, Medicaid. The single best tool to combat the opioid epidemic is Medicaid. This bill would take away the No. 1 tool we have to fight that.

So 220,000 Ohioans right now are struggling with opioid addiction. They are getting treatment for opioid addiction—220,000—they are getting their addiction treatment because they have the Affordable Care Act and insurance provided by the Affordable Care Act. We are going to take that away from them.

At one of my roundtables in Cincinnati—the Talbot House—a father
sitting next to his daughter, who I believe was in her early thirties, looked at me and said: My daughter would be dead from an opioid overdose had it not been for Medicaid expansion. I thank Governor Kasich for having the courage to stand up against his President and do what is right for the residents in this town and do the right thing in expanding Medicaid.

This plan, door No. 2, has higher costs, less coverage, and would kick many of those 220,000 people off their insurance. It would disrupt treatment for hundreds of thousands of Ohioans as they fight for their lives. It would pull the rug out from under local police and communities in the midst of an epidemic.

A number of police officers told me that when they go to a home—a police officer or a firefighter or another first responder—when they go to a home where somebody is unconscious because of an opioid epidemic, first they have to revive them, and the second thing they do is sign them up for Medicaid. They sign them up for Medicaid so they can get treatment. Otherwise, there is a very good chance that person will die.

There is no effective tool for fighting opioid addiction is Medicaid. Yet this body voted today—2 Republicans stood up and voted against this—today, 50 Republicans and the Vice President of the United States, who honored us with his presence today with the tie-breaker—when they voted, voted essentially to kick those people off their treatment.

So door No. 2, the insurance company lobbyist plan: higher costs, less coverage. The same plan written by lobbyists.

Let’s talk about door No. 3. Behind door No. 3 are higher costs and less coverage. It is the same plan written by lobbyists, just with taxpayer dollars thrown in to buy off votes. Same result—higher costs and less coverage.

They can’t just throw money at this bill and make it better.

Take opioids. They want to take away Medicaid, which is the No. 1 tool we have to get people treated, and then they throw in a $45 billion Federal grant program instead.

Governor Kasich said that those dollars—taking away Medicaid, taking away treatment, taking away insurance from the 700,000 Ohioans in Medicaid who have been saving for themselves—would hit the overwhelmingly older—Governor Kasich is a Republican, and he and I see this pretty much the same way. Governor Kasich said that putting that money in after taking away Medicaid is like putting in the ocean.

The director of Ohio’s Medicaid Program said the Republican Senate plan would be devastating for Ohio. For instance, if someone had cancer, I don’t think the best treatment for cancer is to cut off their insurance and then give them 100 pages to pay their oncologist—not even a Federal grant to pay their oncologist. You don’t treat people by a Federal grant, you treat people by insurance and all of the wraparound of insurance that matters.

It is not just those fighting addiction—I talked a lot about opioids—it is kids with special healthcare needs. It is kids in Ohio schools. There is a program called Medicaid Early Intervention Services that young people struggling with various kinds of physical and mental illnesses in the schools. That is helpful.

It is rural hospitals. I have been on the phone with literally four dozen hospital CEOs in this State—at least four dozen, a number of them a number of times—and small hospitals in rural communities know that they may close if this bill, the one behind door No. 3, is adopted.

It is seniors in nursing homes, and it is their families who help care for them. Few people realize that three in five nursing home residents in my State rely on Medicaid to cover the cost of their care. That is 60 percent. They are all our parents and grandparents. These are middle-class families and working-class families who end up in nursing homes. They run out of money at the end of their lives. That is Medicaid dollars. Two-thirds of Medicaid dollars go to children or opioid addiction, they go to nursing homes to take care of our parents and grandparents.

I met with families again in Toledo last week who rely on Medicaid to help afford my son Ford’s treatment.

Bob’s mother Blanche lives at a home in Perrysburg, a suburb of Toledo. My mother and father worked all their lives. My mother is 95 and receives a pension of only $1,500 a month. Medicaid keeps her alive so she is able to spend time with her kids and her grandkids.

I remember Margaret Mead, the great anthropologist, who said that wisdom and knowledge are passed from grandparent to grandchild. A child can spend time with his grandparents, as my daughters got to spend time with their grandparents, especially my grandmother in her last years. It didn’t just bring great joy to the grandparents, it imparts wisdom and understanding and education to the grandchildren. Medicaid does that, too, when people have insurance, when people are taken care of in nursing homes and assisted living.

We talk about people like Blanche who worked hard to build a good life for her children and grandchildren. They paid their taxes. They paid their insurance premiums. They paid into Medicare and Social Security. So we are going to cut their Medicaid in the last years of their lives. They shouldn’t have to lose everything because they need more intensive care in the later years of their lives, and neither should their families, who are already squeezed—people in their fifties and sixties and early seventies—who worry about their children’s education on the one hand and then worry about paying for nursing home care for their parents on the other.

Another huge portion of the people Medicaid helps are Ohioans who are workers, who pay taxes, who have children with a disability or with serious special needs. Nearly 500,000 kids in Ohio—20 percent of Ohio kids, 2 in 10—have special healthcare needs. Boaz, whom I met in Cleveland, was born with several heart defects. He wouldn’t be alive today without treatment covered by Medicaid. Benjamin Dworning from Akron, born with Down syndrome, visited my office recently with his parents.

It is not just kids with special needs who will lose out. Ohio schools could lose $12 million a year. Twenty-two percent of rural hospitals would be at risk of closing. It goes on and on.

These are all problems created by this bill behind door No. 3, written by lobbyists, written down the hall in Senator McConnell’s office by drug company and insurance company and Wall Street lobbyists. That is the bill—undisclosed, unknown until he regurgitated it on the Senate floor and gave us this bill.

Cleveland.com wrote: “As for the proposed $200 billion to ease the path for ACA funding losses, this too would pale compared with the losses themselves."

Again, Governor Kasich—he, a Republican; I, a Democrat—said this is spitting in the ocean.

So that is what is behind door No. 3—higher costs, less coverage. That brings us to door No. 4. What is behind the last door? We have no idea. It is the ultimate mystery plan.

Remember what Vice President Biden said about the uncertainty has already done to Ohio families? There are 20 counties with no insurer next year.

As an editor at the Columbus Dispatch—Ohio’s most conservative newspaper—said to me about a month and a half ago, uncertainty is like carbon monoxide for business, a silent killer.

Now, the Republican Party, whichfashions itself as the party of business, seem to have specialized over the last 10 years in injecting uncertainty into the economy—uncertainties such as, are we going to pass the Export-Import Bank, which Senator Murray worked so hard on, so our companies can export American-manufactured, well-made products? Are we going to pay our debts or are we not going to meet our obligations and shut down the government? Are we going to leave hanging out there the Affordable Care Act? All of these things create uncertainty, and as a result, business investment freezes. We know what happens. So who knows what kind of damage this latest vote will do in the insurance market.

We can be sure for certain is that this mystery plan behind door No. 4 will mean higher costs and it will mean less coverage, because nothing so far—nothing that has been put on the table—could result in anything else. The math doesn’t work. How can anyone stand here and say that 17 of us are standing here and Members of the Senate, all getting insurance provided by taxpayers—how can you stand here and
threaten to take away the insurance of others and at the same time drive up costs.

The Affordable Care Act is not perfect. Of course, it is not. We have work to do. Senator SCHUMER talked today about it. Sit down with us. We would love to work through many of the items and get more young, healthy people into the insurance pool, to stabilize the insurance market, to go after the high cost of prescription drugs and maybe, even to consider Medicare at 55. We were one vote away from opening Medicare in a revenue-neutral way for people between 55 and 64 who might have lost their insurance as they get sick or as they get older. There are all of those options, but don't start with repeal, throwing millions of Americans off of their insurance.

I agree with Governor Kasich one more time. Yesterday, Governor Kasich said: Until Congress can step back from repeal, throwing millions of Americans of those options, but don't start with repeal, throwing millions of Americans off of their insurance.

There has been no bipartisan action in this body's history. We are going up against the American healthcare system, and we don't even know what comes crashing down anyway. We have to do it for the tens of millions of Americans who depend on Medicaid and the ACA. We have to do it for our rural hospitals. We have to do it for the people with preexisting conditions. We have to do it for the people without power, without the ability to walk 200 yards from this gilded Chamber and get the best healthcare in the world.

I will be fine. All the Members of this Chamber will be fine. But our job is not to take care of ourselves. Our job is to represent our constituents, and this bill has earned the title of most unpopular major bill in American history, most unpopular major legislation in American history.

There is still time to walk back from the brink.

I yield the floor.

The PRESIDING OFFICER. The majority leader.

Mr. MCCONNELL. Mr. President, I ask for the yeas and nays with respect to amendment No. 267.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

The SENATE STEAKHOUSE.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Is there objection?

Mrs. MURRAY. Mr. President, I object.

The PRESIDING OFFICER. Objection is heard.

The clerk will report.

The senior assistant legislative clerk read as follows:

The Senator from Kentucky (Mr. MCCONNELL) proposes an amendment numbered 270 to amendment No. 267.

(Purpose: Of a perfecting nature.)

Mr. MCCONNELL. Mr. President, I call up amendment No. 270.

The PRESIDING OFFICER. The clerk will report.

The senior assistant legislative clerk continued with the reading of the amendment.

The senior assistant legislative clerk continued with the reading of the amendment.

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The senior assistant legislative clerk continued with the reading of the amendment.
time caps on coverage, and those caps would hit people who get their healthcare through their employer, as well as those who buy it for themselves in the individual market. You can forget about essential health benefits. You get stuck with high-risk, high-cost, with-bargain-basement insurance plans, as long as you offer one, single, comprehensive option, the kind of plan that actually works for people with preexisting conditions and, by the way, you get to price shop in the marketplace. Under the Cruz proposal, we will be looking at a tale of two healthcare systems in America. The young and healthy are going to opt for the bare-bones insurance plans that don’t cover much of anything, but there are millions of people in this country who cannot get by with skimpy Cruz-plan insurance. They are people who have had a cancer scare or suffer from diabetes. They are people who get on the highway in the morning and have an accident. The only coverage that works for them will come with an astronomical premium.

There was no hearing in the Finance Committee, no hearing in the HELP Committee. Senators are flying in the dark, and as far as I am concerned, the proposal is going to be before us without having been scored by the CBO.

Let me close with this: It is not too late for Republican Senators to put a stop to this shoddy, unacceptable process. Nobody in this Chamber—not even Senator Enzi—has to choose between TrumpCare and straight repeal or any partisan plan. I hope my colleagues will reject TrumpCare 3.0. BCRA 3.0 would say it is time to stop this any-mountain-or-the-highway process and say, after rejecting this ill-considered amendment, that they would like to return to the regular order, where we look to bipartisan approaches.

I urge my colleagues to oppose and to oppose strongly this first amendment that we will vote on tonight, BCRA 3.0. It is a prescription for trouble for millions of consumers, and I think it is time to stop this any-mountain-or-the-highway process, and say it is time to return to the regular order, where we look to bipartisan approaches.

The Affordable Care Act was enacted in 2010. We heard a lot of promises about lower costs. They promised that ObamaCare was going to bring down premium costs by 2,500 bucks for the average family, but we now know that families have seen premium increases higher than inflation. According to the Ohio Department of Insurance, health insurance premiums on the individual market in Ohio have nearly doubled since the Affordable Care Act went into effect 7 years ago. Small business premiums have gone up as well.

Premiums for this year are up double-digits, and next year we all expect the same. No one can afford that.

To make matters worse, we have seen a sharp increase in deductibles. For a lot of people, uninsured by insurance, they feel as though they really don’t have health care insurance at all because their out-of-pocket expenses are so high and deductibles are so high, they really can’t access it.

Higher premiums and deductibles have already made healthcare unaffordable for a lot of hard-working Ohioans. But it is not just about costs, it is also about choice. Some people are losing their choice altogether because the policies established in the Affordable Care Act were set up for failure.

Fifteen of the 23 nonprofit insurers set up around the country as co-ops around the Affordable Care Act have now gone bankrupt. One was in Ohio. Last year in my State, 22,000 hard-working Ohioans lost their coverage because our co-op declared bankruptcy. Many of them, by the way, had already paid their deductibles on that, and they lost that as well.

Worse than that even, right now there are 19 counties in Ohio without a single insurance company in the exchange market, the individual market—not one insurance company. Another 27 counties in Ohio have only 1 insurer. That is not competition. That is not choice. Far too many Ohioans—thousands of them—if they want health insurance, are told they have to move out of their county to another county.

Less competition has also meant less choice and higher costs for Ohio families and cost shifting on to employer-based plans. As these insurance companies have lost money, some of them haven’t left Ohio, but they shifted their costs to other people. That is why so many people’s costs have gone up.

Without competition and choice in the market, we are not able to lower healthcare costs for families and small businesses. That is one more reason why the status quo on healthcare, the system we have now, is not sustainable.

The Affordable Care Act has failed to meet the promises that were made, but we can do better, and we have to do better. It is our job to do better, but we should do it in a way that protects low-income beneficiaries of Medicaid, that protects the most vulnerable in our State. We can do that too.

At the outset of this debate and consistently throughout the debate, I have
said my goal was to create a more workable healthcare system that lowers the cost of coverage and provides access to affordable care while protecting the most vulnerable. This most recent version of the Better Care Reconciliation Act—known as the Senate bill—provides an improvement over the House bill, but it is also an improvement over the previous Senate bill. This measure includes reforms that will help lower premiums on families and small businesses. The No. 1 priority that should be lower is those costs. This bill will help lower those premiums.

Throughout the process, I have expressed my concerns about how we deal with Medicaid, which is a critically important federal program that provides healthcare benefits to about 70 million Americans who live below the Federal poverty line. The Affordable Care Act allowed States, including Ohio, to expand Medicaid eligibility actually above the Affordable Care Act line to 138 percent of poverty, and to cover single adults.

With our growing debt and deficits, we know the current Medicaid Program is not financially sustainable over the long term, and we have to look for innovative new ways to protect and preserve it now so that Ohioans can count on this program in the future and so that those who need it will have it.

My point all along has been that these reforms can and should be done in a way that doesn’t pull the rug out from under people and give States time to adjust. So, in this Senate bill, I have worked to put Medicaid expansion on a glidepath for 6 years, with the current law for 3 years and then a transition for another 3 years. That transition would be to a new healthcare system. This is a big improvement over the House bill, which had a cliff in 2 years without a glidepath.

Just as important, in this substitute before us, Governors would have new flexibility in this legislation to design innovative Medicaid Programs that meet the needs of their States and their expansion populations.

One issue I have focused on a lot in this discussion has been the opioid epidemic. In my own State of Ohio, this epidemic has had a devastating effect. About 200,000 Ohioans now suffer from drug addiction, primarily from heroin and prescription drugs and the new synthetic heroinics, such as fentanyl. Unbelievably, I will tell you that about half of the funds we spend in expanded Medicaid in Ohio go for one purpose, and that is mental health and substance abuse treatment, primarily driven by addiction to heroin and prescription drugs and fentanyl.

We have to deal with this issue in a smart way. In this latest version of the substitute,奇怪 why we fought to provide not only that transition for those on expanded Medicaid but also an additional and unprecedented $45 billion in new resources for States to address the opioid epidemic. I am pleased to say that in the legislation we are going to vote on tonight, it is included. We want those receiving opioid treatment under Medicaid expansion to maintain access to treatment as they work to get back on their feet. This new funding is critical to keeping people in treatment and long-term recovery.

An additional issue I have been working on is to ensure that those on expanded Medicaid are able to find affordable healthcare options under a new Medicaid structure or affordable healthcare options in the private sector on the private market. Over the past few weeks, I have worked with the President, the Vice President, administration officials, and many of my colleagues on ways to improve this bill further in this regard, to help out low-income Ohioans and others who are trying to find affordable coverage.

That is why this proposal before us, the Porterman amendment, is so important. By the way, it is called the Portman amendment, and it is the result of the work of a lot of different Senators, some of whom I saw on the floor earlier and one I see here tonight. Senator Portman has been a leader on this. And Senators Hoeven, Gardner, Sullivan, Cassidy, Young, Boozman, Heller, Murkowski, and others, have worked on this proposal.

I am pleased that we have received a commitment that the Senate will vote tonight on this approach to help those on Medicaid expansion and other low-income Americans get access to affordable healthcare in the private market.

This plan has two parts. First, it provides an additional $100 billion to the long-term stability fund in the Better Care Reconciliation Act to help people with out-of-pocket expenses, such as deductibles and copays, thus ensuring that those who transition from Medicaid over time and who are under a new system not only have the tax credit to help them, which is part of the underlying bill, but also have additional help for affordable coverage options.

Second, it is a Medicaid wraparound that allows States to provide cost-sharing assistance to low-income individuals who transition from Medicaid to private insurance and receive a tax credit on the exchange. The States committing to this flexibility must commit to providing that long-term stability fund increase—the additional dollars I am talking about—to assist individuals with their deductibles, out-of-pocket expenses, and copays.

It would also help the States to capture Medicaid savings in order to support the tax credits under the Better Care Act without having to seek and renew existing waiver authority.

This Medicaid wraparound is already available through a waiver, but we think it is critically important to put it in a statute so that other administrators and the current ones—Seema Verma has said she supports this waiver or begging—but others will grant it, and you don’t have to renew this waiver or beg for a waiver. It is a commonsense way to help get people who are going into private plans the help they need to be able to afford the premiums, deductibles, and copays.

This is a commonsense approach to help ensure that these low-income Americans have access to affordable care, and I urge my colleagues to support it.

We must do better than the Affordable Care Act. I have heard from people across Ohio on both sides of this debate. Trust me, I have heard a lot. There is a lot of passion. I understand that. But it is interesting, the common denominator in many of these discussions is that doing nothing is not sustainable. Pretty much everybody acknowledges that the status quo is not working. Ohioans deserve action.

In my view, to throw in the towel and give up on finding a better alternative is to give up on Ohio’s families, give up on Ohio’s small businesses, and I am not willing to do that.

I do not know how the Affordable Care Act has not lived up to its promises to the American people. Today, after 7 years of consistently calling for repeal and replace, I am supporting a sensible plan to do just that. Is it perfect? No. I don’t think any substitute is. Replacement is hard. But it is an improvement on the unsustainable status quo, and it does help keep our promise to the American people to do better. I urge my colleagues to support the legislation before us.

I yield back my time.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. MARKEY. Thank you, Mr. President.

Mr. President, earlier today the Senate voted on a bill to dismantle this country’s healthcare—a cruel bill that has not lived up to its promises to the American people, and I urge my colleagues to support the Affordable Care Act. That is a travesty.

I have often said that the proudest vote I cast in my career was the one I cast in favor of the Affordable Care Act. The second proudest vote is today, voting no on this cruel, heartless, inhumane bill.
To all of my constituents in Massachusetts, please know that I vote no with you in mind.

Massachusetts is the home of universal healthcare. We have a model for the Affordable Care Act. Because of our belief that healthcare is a right, not just a privilege. Ninety-eight percent of Massachusetts residents have healthcare coverage. That was a dream of the great Teddy Kennedy, the lion of this Chamber, and it is a reality in Massachusetts.

We cannot let this historic vote today proceed to proceed on healthcare legislation, but rest assured, we will fight to protect the Affordable Care Act from era over.

It is a testament to how divined the Republican Party is over how to replace the healthcare law that we believe that version of TrumpCare we will proceed to vote for final passage. It is not because Republicans haven’t had time—they have had 7 years to craft a plan to repeal the Affordable Care Act. Rather, the chaos we have seen so far from Senate Republicans is because millions of Americans are finally benefiting from insurance coverage, many for the first time, and they don’t want those protections taken away.

In many ways, it doesn’t matter which bill they bring up for a vote because all versions of the Republican healthcare bill are terrible. Republicans don’t have a clue idea how they will go about protecting those with pre-existing conditions and ensure that millions aren’t kicked off their current insurance plan.

Senator Republicans have so far proposed three bills that would each devastate the healthcare sector. Take a machete to Medicaid, and make the poorest in our country pay for tax breaks for the wealthiest. These bills are bad, the worse, and the ugly.

First, the bad.

Senate Republicans proposed legislation at the end of June—just a month ago—that would rip away health insurance from 22 million Americans and give the top 400 wealthiest people in our country a tax break worth $33 billion.

Then the worse.

They introduced yet another bill that would kick 22 million Americans off of their health insurance and cut Medicaid by $750 billion. They tried to cut Medicaid, causing irreparable damage to a program that provides coverage for 70 million Americans, and they all hand over millions to the wealthiest in our country, who do not need them or deserve them. Even in Massachusetts, the Republican proposals would mean more than 290,000 people would lose coverage, often the most vulnerable. It is estimated that Medicaid would cost the State more than $8 billion by the year 2025.

There are no changes, no so-called fixes, no modifications to make any of these bills less cruel. Each of the Republican proposals will just exacerbate the most devastating public health crisis facing the country—the battle against opioid overdose deaths.

Leader McCONNELL said today that he would be thinking about the families of people who have died when he casts his vote to kick at least 20 million Americans off of their health insurance coverage. Yet do you know who will really be hurting? It will be the families of the nearly 1,000 people who die of opioid overdose in Kentucky last year.

In a blatantly craven attempt to make TrumpCare more palatable, moderate Republicans from States that have been ravaged by the opioid crisis would include a paltry opioid fund in the most recent version of the GOP replacement fund. Those are crumbs compared to the amount that the Affordable Care Act would likely spend on covering opioid use disorder treatments if we would just leave the law alone to work as intended. This opioid fund is not a fix; it is a falsehood. It is a false promise to the people who are suffering from opioid addiction. It is a false future that will not include critical diagnosis, treatment and recovery services, and it is a false bargain that Republicans will make at the expense of families who are desperate for opioid addiction treatment.

The American people will not be fooled. They realize that opioid funding in this proposal is nothing more than a public health pittance—a wholly inadequate response to our Nation’s preeminent public health crisis. No amount of money in an opioid fund can replace the level of addiction treatment and recovery services that is provided through the comprehensive health insurance program that the Affordable Care Act represents. Families of those who suffer from substance abuse disorders have been shouting from the rooftops that cutting Medicaid and hamstringing access to health insurance coverage will only make a difficult situation worse.

We should be making health coverage and treatment access more robust, not weaker. Today, only 1 in 10 people with substance addiction receives treatment, and it has been estimated that 2 million people who live with opioid use disorders are not receiving any treatment for their disorders. It should not be a surprise to anyone that the epidemic of opioid abuse will only worsen as long as we have a system that makes it easier to abuse drugs than to get help.

The Republican proposals will be a death sentence for millions of people with substance use disorders. A vision without funding is a hallucination. They are cutting the funding for substance abuse. Republicans are turning their backs on their vow to combat the opioid epidemic, and Lindsey Graham is beginning to break his own promise from the campaign trail to “expand treatment for those who have become so badly addicted.” Instead, they are moving forward with a proposal that threatens insurance coverage for 28 million Americans with a substance use disorder—all to give hundreds of billions in tax breaks to billionaires and big corporations—and slashing funding for our Nation’s preeminent public health crisis.

Creating a separate fund for opioid use disorders just further stigmatizes the disease and pushes it back into the shadows. This is not how we treat chronic health conditions in this country. It is insulting to those 33,000 Americans who lost their lives just last year from opioid overdoses.

This latest political maneuver proves yet again that TrumpCare has never been about creating health. It has always been and still is about concentrating wealth—tax breaks for the rich coming from the cuts in healthcare coverage for those who need it the most in our country. They are abandoning hard-working families so that they can fund for themselves while they bestow those gifts of billions in tax breaks to the wealthy. That is shameful.

The GOP replacement plan also imposes an age tax on older Americans, who are already struggling to charge older Americans five times more than younger Americans for the same coverage. That is unconscionable.

The GOP plan reduces access to care for those with preexisting conditions—Americans with cancer, diabetes, women who have had children. They want to force them to pay for a Cadillac, but they then hand over to them a tricycle. That is just plain wrong.

On this floor, it is going to be a battle to make this bill pass. It is going to be a battle to make sure that people who have died every day from substance use disorder are not forgotten. It is going to be a battle to fight for the American people who believe in quality, affordable healthcare will not be silenced by today’s vote. Instead, we will be invigorated to call out the callousness in any of these bills that would threaten the economic security for low-income and working families in our country. We will fight the already overflowing bank accounts of the 1 percent. Oh, no. This fight is just beginning out here on the Senate floor because the lives of all
Americans who would be hurt by the Senate’s vote today to begin debate on repealing the Affordable Care Act are simply too important for us to stop fighting.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mr. CRUZ. Mr. President, today is an important step in a very long journey. Some 7 years ago, ObamaCare passed into law, and in the 7 years that ObamaCare has been on the books, we have seen the results of this catastrophic law. We have seen the devastation that has resulted. ObamaCare is the biggest job killer in this country.

You and I and the Senators who have listened to their constituents across the country have heard over and over again from small businesses that have been hammered by ObamaCare. As I have listened to small businesses in the State of Texas over and over again, they tell me ObamaCare is the single biggest challenge they face.

Indeed, thanks to ObamaCare, we have discovered two new categories of people who have been hurt by the Federal Government—the so-called 49ers and the so-called 29ers. The 49ers are the millions of small businesses that have 47, 48, 49 employees and yet do not grow to 50 because at 50, they would be subject to ObamaCare, and in being subject to ObamaCare, they would go out of business. There are literally millions of these jobs that ObamaCare is forcing to happen, waiting to grow, small businesses ready to expand that ObamaCare penalizes so punitively that they do not expand.

By the way, those jobs that would be the 50th and 51st and 52nd are typically low-income jobs. They are jobs for people who are just starting out in their careers. They are jobs for people who are minorities, who are African Americans, who are Hispanics. They are jobs for people whose premiums had skyrocketed. After 7 years of stonewalling and obfuscation, and the so-called 29ers, the single moms who are trying to do something. Today, we had a vote to take the first step in doing something—in honoring the promise every Republican made to repeal this disaster.

The bill before the Senate is not perfect. No one would expect it to be perfect. Bismarck’s comments about sausage-making are certainly true in this process here today. Yet I will say that in the bill before the Senate, which is not likely to pass tonight—but I believe, at the end of the process, the contours within it are likely to be what we enact, at least the general outlines—there are at least four positive elements that are significant.

No. 1, it repeals the individual mandate. The IRS fines about 6.5 million people a year because they do not have the money for healthcare. The IRS fines you on top of it, and you still do not get healthcare. That is a terrible outcome. This bill will repeal the individual mandate, repeal the IRS fines on 6.5 million Americans, the job-killing fines of the individual mandate.

It also repeals the employer mandate, which is the driver of the 29ers and 49ers. For 7 years, the Democrats had no answer to the single mom forced to work part time. Repealing the employer mandate provides relief to everyone who finds himself in those camps.

No. 3, this bill has a major reform that allows people to use health savings accounts—pretax money—to pay for insurance premiums. That means, for millions of Americans, their effective premium rates instantly drop 20 to 30 percent by using pretax money. That is a major reform for empowering you, the consumer, to choose the healthcare for your family.

No. 4, the bill before the Senate includes the consumer freedom amendment—an amendment that I have introduced like the health savings account amendment. This amendment that says you, the consumer, should have the freedom to choose the healthcare that is best for your family. You should have the freedom. You shouldn’t have to buy what the Federal Government mandates that you must buy. It is the job of the government to meet the needs for you and your family.

The consumer freedom amendment was designed to bring together and serve as a compromise for those who support the mandates in title I. The consumer freedom amendment says that insurance companies, if they offer plans that meet those title I mandates—all the protections for pre-existing conditions—they can also sell any other plan that consumers desire. So it takes away not just if you like your ObamaCare plans, those are still there. It just adds new options and lets you decide: Do you want the ObamaCare option or do you want something else that is affordable? Rather than getting fined by the IRS, you can actually purchase something you and your family can afford.

Now, our friends on the Democratic aisle have been unwilling to look at any option expanding consumer freedom. They just say it won’t work. What we know won’t work is ObamaCare. We know premiums have risen over $5,000 a year. What happens with the consumer freedom amendment? And this is critical. Over the past 2 weeks, the Department of Health and Human Services conducted a study on the impact of the consumer freedom amendment. They concluded, No. 1, it would expand insurance coverage by 2.2 million people. Our friends on the Democratic aisle are constantly alleging that repealing ObamaCare will cause chaos. Well, HHS found the consumer freedom amendment expands it by 2.2 million people.
But what does it do to premiums? This is powerful. HHS found that it will reduce premiums by over $7,000 a year. If you are a single mom, if you are a school teacher, if you are a truck-driver, $7,000 a year is a lot of money. It is the difference between making ends meet and perhaps, HHS found specifically that for those choosing freedom plans—the less expensive options—premiums would drop $7,260 a year.

But what about those on the exchanges? What about those purchasing plans subject to all of the mandates? HHS found those plans would also drop, they projected by $5,580 a year. So consumers benefit across the board with lower premiums.

This has been a process. At the end of this process, it is not clear what the Senate is going to pass, what is going to bring together and unite the Republican conference because, sadly, the Democrats are not willing to help us provide more consumer freedom, to help us provide relief to the 49ers and 29ers who have been hammered by this bill. But I believe the key to getting this done—and I believe we can and will get to yes. We are not likely to get to yes tonight, but we can and will get to yes. I think the key to it is the consumer freedom amendment, if we are lowering premiums. If Texans, if Montanans, if people across this country are going home and now premiums are a year cheaper with protections for pre-existing conditions or $7,000 cheaper if you want a catastrophic plan on a freedom plan, that is a win for everyone. It is a win for conservatives. It is a win for moderates. It should be a win for Democrats. If Democrats were not engaged in this partisan fight, Democrats ought to be saying that lowering premiums $5,000 or $7,000 is a win for our citizens. That, I believe, will be the key to getting this done.

Let me finally say that there is rhetoric about insurance companies. Do you know who loves ObamaCare? It is insurance companies. Under ObamaCare, the profits of the top 10 insurance companies have doubled. When you have the IRS fining people to force them to purchase their product and driving up premiums so they are unaffordable, ObamaCare effectively sets up a cartel for the large insurance companies. Consumer freedom puts you, the consumer, in charge of your choices. Instead of the giant insurance companies, instead of the Federal Government, it puts you in charge. Freedom is the key to unifying our conference, and lowering premiums is the key, and I believe we can and will get this done.

With that, Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon?

Mr. MERKLEY. Mr. President, we are now considering the Cruz amendment, which he titles consumer freedom, but there could not be a more

mismarked amendment to come to the floor.

Americans know this as the fake insurance amendment. This is the amendment that says: Hey, insurance companies, we are going to do you a huge favor by allowing the policies that aren't worth the paper they are written on. And, Hey, isn't this wonderful, says my colleague from Texas, because, you know what, people will only have to pay a few dollars per month for those worthless policies, and that is free.

Well, I will tell you that if my colleague had been out talking to people in rural America, as I have been, if he had been out there talking to people in red America, as I have been, he would be hearing that people are terrified about this effort to annihilate health insurance.

One out of three people in Oregon have been able to be on the Oregon Health Plan. ObamaCare has had an incredible impact on our rural healthcare centers. Many of them have doubled their number of employees. About 20,000 employees across the State have been added. Oh, we just heard a speech about it being a job killer, but those employees thousands and thousands more people in the healthcare industry across America. Little communities that didn't have folks being able to take on mental health can now take on mental health in their communities. Rural communities that didn't have a drug treatment program now have a drug treatment program. Rural hospitals that were going out of business now have a strong financial foundation. And that is just the beginning.

Entrepreneurs across this Nation were tied up in their companies, afraid to leave and pursue their vision because they couldn't get healthcare by themselves. Now, they can, so they are starting one business after another. And what we have seen is month after month after month of growth in employment in this Nation.

Oh, we can tell you about the amendment that my colleague from Texas is putting forward and what it does in terms of offering these fake policies, but that is only the beginning of it because what it is designed to do is carve off those who are young, carve off those who are healthy, and put them into one pool into one exchange. And then he goes on to say, "The people who don't know something will happen and come down with something, those are the ones at issue." Or let's turn to the American Action Forum Deputy Director Tara O'Neill Hayes, who says: "I think that really would be the definition of a death spiral."

Or we can turn to the former CBO Director, Douglas Holtz-Eakin, who says "What that will do is allow insurers to offer cheap policies to young invincibles. And on the exchange you're going to get all the sick people."

He continues and says: "That's a recipe for meltdown. You've split the risk pool into two exchanges."

And he says: "I think it would end up being bad politics."

I am concerned about bad politics, but I am concerned about those folks whom I have been meeting out in rural America, out in red America, because they are coming to my townhalls and they are saying: Stop this diabolical, evil amendment. The Cruz amendment, if we are lowering premiums, it makes it a lot worse by creating the fake policies for the young and healthy—the young invincibles—and the death spiral insurance for everyone else.

So someone can stand up here and speak glibly about how this is going to fix job creation in America, but what it really says is healthcare for the wealthy—not healthcare, but wealth care.

It is so interesting to see this whole coalition of individuals who want to pass a bill that not only demolishes healthcare for 22 million, but gives hundreds of billions of dollars to the very richest in America. My colleague mentioned a moment ago that the richest 400 families would get $33 billion. No, not $33,000 apiece or $33 million—$33 billion. They feel it is so important to rip healthcare from ordinary working families to deliver benefits to the most wealthy Americans. That is the opposite—opposite—of what we should be doing in America.

Franklin Roosevelt said that the test of our progress is not whether we add more abundance to those who have much; it is whether we do enough for those who have too little. What that translates to is whether we provide a foundation of affordable healthcare so that every family in America has a foundation to thrive. That is what we are fighting for.

This amendment is absolutely a bomb going off in healthcare on both ends of the spectrum, with the young and with the old, with the healthy and
with the sick, and with those with pre-existing conditions.

So let’s defeat this amendment and make sure we don’t make a really terrible bill a lot worse.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. CRUZ. Mr. President, unfortunately, there is far too much scare-mongering that occurs in the political world. But as John Adams famously said: “Facts are stubborn things.”

My friend from Oregon just described the consumer freedom amendment as “a bomb going off in healthcare.” That is interesting rhetoric, but it is disconnected from the actual facts.

Let’s talk about what my friend from Oregon neglected to mention or respond to in any way, shape, or form. He said not a single word about HHS finding that the consumer freedom amendment would expand insurance coverage by 2.2 million people. He had not a word to say in response to that. And he did say is that those who might choose freedom plans would be choosing what he called junk insurance.

Well, it is very nice that ObamaCare mandates that every person must buy a full-ridded Cadillac plan with all the coverages. The problem is there are millions of people who can’t afford it. Not only can they not afford it, they get fined by the IRS because they can’t afford it. My friend from Oregon said not a word about the 6 million people fined by the IRS, roughly 50 percent of whom make $25,000 a year or less.

It is interesting that Democrats are advocating fining people who make $25,000 a year or less because they can’t afford insurance. And what they say is: Look, we are going to fine you until you can afford to buy the full Cadillac plan. Well, you know what, if you are a young woman, you are 28 years old, you are just starting your career, you are making $20,000 a year, you may not be able to afford the full Cadillac plan, but you might like some coverage. You might like catastrophic coverage. So if you get a cold, you break your arm, you cover that out of your health savings account perhaps. But if, God forbid, you get some terrible disease or hit by a truck, you would like to have an insurance policy.

Sadly, our friends the Democrats say that you are out of luck. If you can’t pay your fined Cadillac, you get nothing. They think your choices are junk insurance.

Remember when Barack Obama said that if you like your insurance plan, you can keep it? Well, listen to how the Democrats have moved today. If they don’t like your insurance plan, they can’t keep it. If they think your plan is junk, you can’t keep it, and they are going to fine you through the IRS. I think you know better what your family wants.

The consumer freedom amendment doesn’t take away a single choice. If you like the ObamaCare plans, they are still on the market with all of those mandates. But the Democrats are terrified of freedom. They are terrified that if people actually had the choice, they might not choose the full Cadillac; they might make a different choice.

But then in the world of scare-mongering, Oregon also said: Well, those on the ObamaCare exchanges would go into a death spiral, would see their premiums spike. Remember that John Adams quote about facts being stubborn things? Here is something else my friend from Oregon ignored, said nothing about. HHS found that for those on the exchanges, with all the title I mandates, including preexisting conditions, their premiums would drop by over $5,500 a year.

So the question is, Who is more trustworthy, the experts at HHS analyzing what would occur with competition and choices in the marketplace or the Democrats on this? The Democrats are offering a bomb going off in healthcare. Well, there is an irony in that: In that No. 1, roughly half of the people paying the IRS fines are making less than $25,000 a year. It is the Democrats who are fining low-income people.

No. 2, do you know who agrees with the Democrats on this? The insurance companies. Indeed, my friend from Oregon was reading from the insurance companies. Why have the top 10 insurance companies had their profits double? Because of the Democrats’ mandates. Do you have to buy their products? None of them want premiums to lower.

Of course, the insurance companies don’t want premiums, more options, and your premiums going down. They want to stick it to you as much as they can. Sadly, I don’t understand why, but the Democrats are standing in arm in arm with the insurance companies, saying their profits need to increase even more. I don’t know, maybe they cynically believe eventually it will push it to single-payer socialized medicine. I don’t know why they do it, but what is wealth care is ObamaCare fattening the insurance companies at the expense of working men and women.

Facts matter, and if our friends on the Democratic side of the aisle want to raise accusations, they need to stay in the realm of reality and deal with actual facts: You want lower premiums, you want more choices, more options, more competition. You want higher premiums, you want fewer choices, less options, less competition. That is ObamaCare. And it is why millions of people are hurting and frustrated. It is why today is an important day.

I yield back the remainder of my time.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. MERKLEY. Mr. President, of course my colleagues in Texas made this big rant a little while ago about how ObamaCare is a job killer. When I pointed out it has created jobs all over our country in healthcare, no response. When I pointed out it has created the opportunity for entrepreneurs to create jobs and healthcare jobs, no response. When I pointed out it creates fake insurance that doesn’t cover anything when you get sick, no response. All he has to say is that it makes insurance a little cheaper.

Yes, it is worth the paper it is printed on. Well, not even that, actually, because you pay $40 or $50 a month, you go to the hospital, not covered. If you get in an accident and you need an MRI, not covered. You and your spouse have the opportunity and have a child, not covered. Not covered, not covered, not covered. Fake insurance.

It is the experts who say it throws it into a death spiral. That is why the experts who are advocating fining people who make $25,000 a year or less. How many of them are being fined by the IRS, roughly 50 percent of whom make $25,000 a year or less?

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more damaging—and anyone who believes differently is refusing to see the writing on the wall. I urge my Democratic and Republican colleagues to vote against this bill and every other version of it that we are going to see in the coming hours and days.

Mr. President, I yield back all of our time.

The PRESIDING OFFICER. Is all time yielded back?

The Senator from Washington.

Mrs. MURRAY. Mr. President, I raise a point of order that the pending amendment violates section 311(a)(2)(B) of the Congressional Budget Act of 1974.

The PRESIDING OFFICER. The Senator from Texas.

Mr. CRUZ. Mr. President, pursuant to section 904 of the Congressional Budget Act of 1974 and the waiver provisions of applicable budget resolutions, I move to waive all applicable sections of that act and applicable budget resolutions for purposes of amendment No. 270 and, if adopted, for the provisions of the adopted amendment included in any subsequent amendment to H.R. 1628 and any amendment between Houses or conference report thereon, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion. The clerk will call the roll. The legislative clerk called the roll. The yeas and nays resulted—yeas 43, nays 57, as follows:

[Roll Call Vote No. 168 Leg.]

YEAS—43

Alexander
Barrasso
Blunt
Boozman
Burk
Capito
Cassidy
Cochran
Conley
Crapo
Cruz
Daines
Enzi
Ernst
Fischer

YEA5—57

Alexander
Barrasso
Blunt
Boozman
Burk
Capito
Cassidy
Cochran
Conley
Crapo
Cruz
Daines
Enzi
Ernst
Fischer

The PRESIDING OFFICER (Mr. Young). On this vote, the yeas are 43, the nays are 57.

Three-fifths of the Senators duly chosen and sworn not having voted in the affirmative, the motion is rejected.

The point of order is sustained and the amendment falls.

The PRESIDING OFFICER. The Senator from Indiana.

AMENDMENT NO. 271 TO AMENDMENT NO. 267

(Purpose: Of a perfecting nature.)

Mr. ENZI. Mr. President, I call up the Paul amendment No. 271.

The PRESIDING OFFICER. The clerk will report.

The senior assistant legislative clerk read as follows:

The Senator from Indiana [Mr. Enzi], for Mr. PAUL, proposes an amendment numbered 271 to amendment No. 267.

Mr. ENZI. I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is printed in today’s Record under “Text of Amendments.”

The PRESIDING OFFICER. The Senator from Indiana.

MOTION TO COMMIT

Mr. DONELLY. Mr. President, I have a motion to commit at the desk. The PRESIDING OFFICER. The clerk will report the motion. The senior assistant legislative clerk read as follows:

MOTION TO COMMIT WITH INSTRUCTIONS

The Senator from Indiana [Mr. Donnelly] moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) strike provisions that will—

(A) reduce or eliminate benefits or coverage for individuals who are currently eligible for Medicaid;

(B) prevent or discourage a State from expanding its Medicaid program to include groups of individuals or types of services that are optional under current law; or

(C) shift costs to States to cover this care.

Ms. KLOBUCHAR. Mr. President, I ask unanimous consent that the text of my motion to commit be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Klobuchar moves to commit the bill H.R. 1628 to the Committee on Finance of the Senate with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) provide a tax credit to small businesses for each employee enrolled in their health plan who is 50 years of age or older.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Klobuchar moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) would help rural hospitals stay open, maintain emergency room care, and provide access to outpatient services.

Ms. KLOBUCHAR. Mr. President, I ask unanimous consent that the text of my motion to commit be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

Ms. Klobuchar moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) repeal the noninterference clause under the Medicare part D prescription drug program in order to allow the Secretary of Health and Human Services to negotiate for the best possible price for prescription drugs.

Mr. PETERS. Mr. President, I intend to move to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

No. 1, are within the jurisdiction of such committee; and, No. 2, would ensure that the bill does not increase costs, reduce benefits, or eliminate health coverage for any veteran or dependent of a veteran enrolled in traditional Medicaid, expanded Medicaid, or a qualified health plan offered through an exchange.

I am offering this motion because the legislation as written could harm millions of veterans and their dependents currently enrolled in traditional Medicaid, expanded Medicaid, or a qualified health plan through an exchange.

The following Senators support my motion to commit: DUCKWORTH, STABENOW, CARPER, WHITESHIRE, SHAHEEN, BLUMENTHAL, HIRONO, REED, DURBIN and BALDWIN. I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Klobuchar moves to commit the bill H.R. 1628 to the Committee on Finance of the Senate with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) would ensure that the bill does not increase costs, reduce benefits, or eliminate health coverage for any veteran or dependent of a veteran enrolled in traditional Medicaid, expanded Medicaid, or a qualified health plan offered through an Exchange.
The PRESIDING OFFICER. The Senator from Wyoming.

MORNIGN BUSINESS

Mr. ENZI. Mr. President, I ask unanimous consent that the Senate be in a period of morning business, with Senators permitted to speak therein for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

TRIBUTE TO SABRA FIELD

Mr. LEAHY. Mr. President, Vermont is a place of natural, exquisite beauty. From the expansive, rolling Green Mountains, to the crystal shores of Lake Champlain, Vermont is home to some of the most iconic geographic scenery our country has to offer. I am so proud to call Vermont my home.

Vermont is also continually ranked as having the most artists per capita than any other State. Our many artists—writers, photographers, painters, sculptors, potters, and more—help capture the iconic beauty that has long made Vermont a destination for visitors and the country around the world. One such artist, Sabra Field, is among the most gifted and extraordinary of them.

Sabra first came to Vermont in 1953 to attend Middlebury College. An Oklahoman by birth, she has been lauded as a “Vermont Living Treasure.” Perhaps most well-known for her vivid landscapes, Ms. Field’s impressive and iconic paintings are now of signature familiarity across our State and beyond. Any Vermonter who sees a painting of purple mountain majesties against a starry, blue night sky knows they are looking at one of her paintings.

In 1991, Sabra was commissioned by the U.S. Postal Service to create a postage stamp of a red barn, blue sky, and green hills, a stamp which sold more than 60 million copies. She has also designed images for IBM, the Rockefeller Center, and UNICEF.

Yet what most suspect only to be Ms. Field’s effort to capture Vermont’s impressive geography may be surprised to discover that the meaning behind her artwork spans much further. In a new exhibit of Sabra’s six-decade long career, showcased by the Middlebury College Museum of Art, her artistry takes on a deeper meaning, as told by the artist herself.

The Middlebury exhibit showcases some of Ms. Field’s most iconic pieces, with each painting accompanied by a description of the memory or inspiration behind it. For instance, in a caption situated under an illustration of a family of hippopotamuses, Sabra writes of her first child who was hit by a car just short of his 10th birthday and died tragically 2 days later. In a 2011 panoramic painted of Hawaii, she captions the image of her late husband, Spencer, who passed away on his favorite island of Kauai from complications related to cancer. The exhibit also depicts her work beyond that of a pastoralist, with self-portraits and paintings inspired by her personal exploration of spirituality, mythology, the cosmos, world history, and life after death.

These images and others reveal the often somber trials of Ms. Field’s life. They also expose the ways in which her artistry has helped her heal and grow over time. Ms. Field is hoping this new exhibit will help avoid her being known as purely a pastoralist, as she feels her art is both an expression of beauty and a representation of the obstacles and rebounds of her life.

Marcelle and I would like to congratulate Sabra on her new exhibit at Middlebury College and on her career of record accomplishments. Her treasured paintings have long been a gift to Vermont and the world, and we know her work’s timeless beauty will tell stories for generations to come. Our home proudly displays many of her works. I am so proud to call Sabra our dear friend.

I ask unanimous consent that a copy of the article “Sabra Field Show Reveals Personal Peaks and Valleys,” published in the Vermont Digger on July 16, 2017, be printed in the RECORD.

TRIBUTE TO SABRA FIELD

[From Vermont Digger, July 16, 2017]

SABRA FIELD SHOW REVEALS PERSONAL PEAKS AND VALLEYS

(By Kevin O’Connor, Middlebury)

The first words of a new exhibit celebrating one of Vermont’s most recognized artists sum up the seeming dilemma: “What can one say about Sabra Field’s work that has not already been said?”

Plenty. The 82-year-old printmaker soon proves. Take her 1962 illustration of a family of sunny, smiling hippos.

“Here is the announcement for my first child, Barclay Giddings Johnson III, ‘Clay’ for short,” she writes in an accompanying caption. “He was a handsome boy, a first born of fearless energy, loved and admired by adults and kids alike. Hit by a car just short of his 10th birthday, he died two days later.”

Next comes a 1965 self-portrait featuring more shadows than light.

“This is me the year I grew up, age 30,” she writes, “when my parents died within a week of each other.”

Then there’s the 2011 panorama “Sea, Sand, Stones” that Field composed while visiting Hawaii with her husband.

“Spent days flying to the remote island, Kauai, from complications dating back to cancer seven years earlier,” she writes. “A set of these prints now hangs in Wilcox Memorial Hospital in my hometown of Topsham, Maine. The ER doctor who tried so hard to save him has become a good friend.”

Most Vermonters think of Field for works as colorful and carefree as the red barn, blue sky and green hills she created for a 1991 U.S. postage stamp that sold more than 60 million copies.

“Over the course of her career she has received any number of accolades, and has been variously described as ‘the Grant Wood of Vermont,’ the artist laureate of the Green Mountains, and ‘the only Vermont artist to have touched more lives than any Vermont artist in history,’” says Richard Saunders, Middlebury College professor and director of its Museum of Art.

But the surprisingly personal “Sabra Field, Then and Now: A Retrospective” on campus through Aug. 13 reveals as much about her private struggles as her professional success.

“The Direction of One’s Wishes”

Field, born in Oklahoma and raised in New York, first came to Vermont in 1960 to attend Middlebury, where she graduated 60 years ago (“I went to Middlebury because there was no math requirement,” she confides in the show’s catalog.) She has given the college an archive copy of every print she has ever created. Writing her own captions, the artist uses the 100-work exhibit to chart her career, starting with a 1971 image of swaying green stripes titled “Grass.”

“My first home run,” she notes. “I inadvertently hit a universal theme that got copied and got me to begin registering work with the Library of Congress.”

On another wall, Field’s 2001 “Eastern Mountains” features a more detailed landscape of emerald, turquoise and gold.

“The trip from coastal Maine to Vermont crossed the White Mountains and Hampshire and gives a view of the Upper Valley perhaps not as broad and agricultural as in my dreams,” she writes. “Memory alters in the direction of one’s wishes.”

“Eastern Mountains” proves the point. Field began the first proofs on Sept. 11, 2001, just before seeing television coverage of that day’s terrorist attacks.

Every peak in this artist’s world is framed by valleys, the exhibit shows. Consider the 1969 work “Daisies,” which was published as a print and also as a hand-printed greeting card, she explains, “an enterprise found to be hugely unprofitable.”


Then again, every valley in this artist’s world is followed by peaks. That two-century-old structure, in the Windsor County settlement of East Barnard, is where Field began to design, draw and cut the woodblocks that have sustained her for the past 50 years.

“I became part of a different culture where I could live and work at home in a quiet hamlet that was good for kids and without pressure,” she continues. “Here I am sitting in front of my window overlooking a dirt road with alfalfa on the other side and a quote from George Weld on the window frame that reads ‘Therefore Choose Life’.”

“LIKE ARTISTS ALWAYS HAVE BEEN”

Field’s subsequent 1972 suite of prints depicting the words of the 23rd Psalm allowed her to mark the death of her firstborn son through images ranging from a wintry day (“Yea, though I walk through the valley of the shadow of death, I will fear no evil”) to a Full Moon Summer Night (“Surely goodness and mercy will follow me all the days of my life”).

As writer Nancy Price Graff notes in an essay that anchors the show’s catalog: “For the first time, she turned to Vermont’s landscape to illustrate humankind’s spiritual connection to nature and nature’s capacity to heal those who give themselves to it.”

Adds Saunders: “While on the one hand she has been accused of sanitizing the Vermont landscape, with all the details that surround us, others would say this is a natural part of a desire to see beyond the
mundane and urge us to sense the spiritualism that surrounds us."

And Field: "I know I see Vermont through rose-colored glasses. I know what drive poverty we suffer here. But I guess I am like artists always have been. They want to see things at their best."

As an example, the artist pictures herself in a 1980 self-portrait working in front of a seemingly limitless horizon.

"Reagan started a recession, sales started to slump," she confides in the caption. "An amazing start up, The Mountain School of Milton Academy, hired me to teach gifted high school juniors a few days a week and the commute to Vershire, Vermont, was so beautiful it resulted in many new prints."

(The self-portrait, its subject adds, features a "fabulous Ralph Lauren red suede skirt I was touting trying on in New York City" but ultimately never buying.)

The exhibit includes several landscapes that viewers may recognize from cards, calendars and Vermont PBS pledge drives.

"I believe prints are a popular art form, meant for collectors of modest incomes, as well as those who can spend a lot," the artist explains. "It's been that way since the first woodblock prints were sold to pilgrims as souvenirs at the shrines of Europe in Medieval times."

But Field's art wasn't always seen as marketable. Take the story behind her 1977 "Mountain Suite."

"Vermont Life magazine requested a seasonal suite to sell," she writes. "Then they declined to buy them from me."

The artist went on to distribute the four images herself. (On her website they now sell for $250 each.) Vermont Life, for its part, profiled her in 1979 and put one of her prints on its cover in 1986.

"LIFE AFTER LIFE? YOU TELL ME"

Success has allowed Field to travel the world and take creative chances. Her 12-panel "Pandora Suite," depicting the Greek myth of the first goddess to appear in human form, came in response to the United States' 2003 invasion of Iraq.

"My future was doubtful that summer of 1967," she writes in the caption. "These words by a black American writer living in Paris, described this white American printmaker in New England, and they still do: 'It seems to me that one ought to rejoice in the fact of death, ought to decide indeed to earn one's death by confronting with passion the conundrum of life.'"

BUDGETARY REVISIONS

Mr. ENZI. Mr. President, section 3001 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017, allows the chairman of the Senate Budget Committee to revise the allocations, aggregates, and levels in the budget resolution for legislation related to healthcare reform. The authority to adjust is contingent on the legislation not increasing the deficit over the period of the total of fiscal years 2017-2026.

I find that S. Amdt. 267 fulfills the conditions of deficit neutrality found in section 3001 of S. Con. Res. 3. Accordingly, I am revising the allocations to the Committee on Finance, the Committee on Health, Education, Labor, and Pensions, HELP, and the budgetary aggregates to account for the budget effects of the amendment. I am also adjusting the unassigned to committee savings levels in the budget resolution to reflect that, while there are savings in the amendment attributable to both the HELP and Finance committees, the Congressional Budget Office and Joint Committee on Taxation are unable to produce unique estimates for each provision due to interactions and other effects that are estimated simultaneously.

I ask unanimous consent that the tables, which provide details about the adjustment, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

BUDGET AGGREGATE REVENUES

(Pursuant to Section 311 of the Congressional Budget Act of 1974 and Section 3001 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017)

<table>
<thead>
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<th>$ in millions</th>
<th>2017</th>
<th>2017–2021</th>
<th>2017–2026</th>
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<tr>
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</table>

REVISION TO ALLOCATION TO THE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

(Pursuant to Section 302 of the Congressional Budget Act of 1974 and Section 3001 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017)

<table>
<thead>
<tr>
<th>$ in millions</th>
<th>2017</th>
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<th>2017–2026</th>
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</table>
TRIBUTE TO SCOTT ALVAREZ

Mr. CRAPO. Mr. President, today the Senator from Ohio and I wish to speak about Scott Alvarez, general counsel of the Board of Governors of the Federal Reserve System.

Mr. Alvarez is retiring after a 36-year career with the Board of Governors, including the last 12 as general counsel.

He joined the board’s legal division in 1981, immediately after graduating from Georgetown Law School, and worked as a staff attorney on bank regulatory issues for many years, until he was named general counsel in 2004.

In that role, he served as a key advisor to Chairmen Greenspan and Bernanke and Chair Yellen.

He was also general counsel of the Federal Open Market Committee, and he was the chief lawyer in carrying out some of the Fed’s other roles, including overseeing the payments system and issuing currency.

I have enjoyed working with Mr. Alvarez over the years and have appreciated the insights and feedback he has provided to me and the Banking Committee.

On a personal note, his help was particularly valuable in 2006, when the Senate passed the Financial Services Regulatory Relief Act of 2006, which was then signed into law by President Bush.

I want to thank Mr. Alvarez for his assistance on that bill and others and for his service to the Federal Reserve and to the country.

Mr. BROWN. Mr. President, I want to echo the comments of the senior Senator from Idaho, the chairman of the Banking Committee, and thank Mr. Alvarez for his service at the Federal Reserve.

I specifically want to thank him for his service during the financial crisis of 2008. Our country faced daunting challenges during that period, and the Federal Reserve and the government’s response to the financial crisis was not an easy undertaking.

The crisis demanded great effort and ingenuity from many people. It required close coordination across the executive branch, the regulatory agencies, Congress, and the private sector.

Working with key decisionmakers at the board and throughout the government, Mr. Alvarez played an important role in developing and articulating the legal dimensions to virtually every initiative taken by the Federal Reserve to address the crisis.

Mr. Alvarez also worked closely with Congress during consideration of the Dodd-Frank Wall Street Reform and Consumer Protection Act and played a crucial role in implementing rulemakings required of the Federal Reserve by Dodd-Frank. I am particularly grateful for the work he did to implement strong rules to increase the capital and leverage requirements for the Nation’s largest banks—a necessary and critical step after the crisis—and the work that he did with my office in making one of the first substantive amendments to Dodd-Frank related to capital standards for insurance companies.

Scott Alvarez has served the Federal Reserve and the American people with great distinction and deserves thanks for a job well done.

ADDITIONAL STATEMENTS

TRIBUTE TO DR. TEMPLE GRANDIN

- Mr. GARDNER. Mr. President, today I wish to honor Dr. Temple Grandin’s induction into the National Women’s Hall of Fame. Dr. Grandin is an internationally recognized leader for her work in animal sciences and autism awareness. I would also like to wish Dr. Grandin a happy 70th birthday.

Dr. Grandin has contributed immensely to the study of animal sciences and the agriculture industry. She has been an esteemed college professor at Colorado State University for more than 20 years and much of her research and inventions have become standard industry procedure, like humane cattle slaughter. She began her career in the early 1970s and was one of only a handful of women working in animal sciences. She paved the way for other women to thrive in this industry.

In addition to her professorship, Dr. Grandin has become a well-known advocate and spokeswoman for autism awareness. She has published countless books about living with autism and has been recognized on the Time Magazine’s Top 100 Most Influential People under the ‘Heroes’ category. She has received honorary degrees from 13 universities across the country and around the world. Dr. Grandin has also received numerous industry awards for her significant contributions to agriculture, as well as her advocacy for autism awareness.

Dr. Grandin has undoubtedly left a lasting impression on the animal sciences and autism advocacy. I congratulate her induction into the prestigious National Women’s Hall of Fame and again wish Dr. Grandin a very happy birthday.

TRIBUTE TO JAKOB HELLER

- Mr. HELLER. Mr. President, today I wish to recognize my nephew, Jakob Heller, on his upcoming achievement of becoming an Eagle Scout, one of the highest honors in the Boy Scouts. On August 2, 2017, Jakob officially becomes an Eagle Scout, which serves as a symbol of his dedication to the Scouts’ mission of creating responsible, participating citizens and leaders.

In order to become an Eagle Scout, Jakob completed tests and earned merit badges that required mastering specific outdoor skills and providing services to his community. He also demonstrated a commitment to his team and the Boy Scout mission and oath.

Jakob comes from a military family, and like many military families, they are constantly on the move. Jakob’s father served in the U.S. Navy, and after retirement, he moved his family to southern West Virginia where they have been living for the last 5 years. I am happy to note that, following his Eagle Scout ceremony, Jakob and his family will be moving to Carson City, NV, where his grandparents and extended family anxiously await his arrival.

Jakob is a talented young man who excels academically and participates in a number of extracurricular activities. In addition to his academic accomplishments, he is a gifted musician who...
plays the trumpet in the marching band and the French horn in the school’s concert band. He is also a member of the cross-country team and participates in track and field, where he shines in sprint relays, hurdle events, and long jump. His ability to balance school, athletics, and Boy Scouts is truly remarkable.

Furthermore, Jakob is preparing for a future in computer programming. Like many kids his age, he loves playing video games and is interested in becoming a video game programmer. Additionally, he is part of his school’s robotics club and programs robots to compete in challenging competitions. With such extensive experience at a young age, I am confident Jakob will have a bright future as a computer programmer.

Jakob is responsible and dependable and understands the importance of his family, friends, and community. Boy Scouts has had a positive impact on his life, and I know that he will serve as an excellent role model for other members of his family and friends.

In closing, I ask my colleagues and all Nevadans to join me in congratulating this new Nevada resident, my nephew Jakob Heller. I cannot be more proud of this young man, and I look forward to witnessing his many contributions to our community in the years ahead.

TRIBUTE TO PAUL KASTER

Mr. ROBERTS. Mr. President, today I wish to recognize the distinguished accomplishment of Kansan Paul Kaster on the occasion of his 2017 National Federation of Independent Business, NFIB, Young Entrepreneur Award.

Mr. Kaster, of Leawood, KS, is the founder and owner of Crooked Branch Studio, which specializes in woodworking. I ask that my colleagues join me in recognizing Paul on his outstanding achievements. I wish him nothing but the best for his future entrepreneurial and educational endeavors.

MONROE COUNTY BICENTENNIAL

Ms. STABENOW. Mr. President, today I wish to recognize the distinguished accomplishment of Kansan Paul Kaster on the occasion of his 2017 National Federation of Independent Business, NFIB, Young Entrepreneur Award.

Mr. Kaster, of Leawood, KS, is the founder and owner of Crooked Branch Studio, which specializes in woodworking. I ask that my colleagues join me in recognizing Paul on his outstanding achievements. I wish him nothing but the best for his future entrepreneurial and educational endeavors.

TRIBUTE TO DEVIN MARTIN

Mr. THUNE. Mr. President, today I recognize Devin Martin, one of my Washington, DC, interns, for all of the hard work he has done for me and my staff at the Senate Republican Conference.

Devin is a graduate of Huntley High School in Huntley, IL. Currently, he is attending the University of South Dakota in Vermillion, SD, where he is majoring in journalism and political science. Devin is a dedicated worker who has been committed to getting the most out of his experience.

I extend my sincere thanks and appreciation to Devin Martin for all of the fine work he has done and wish him continued success in the years to come.

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Ridgway, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(Messages received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

At 12:29 p.m., a message from the House of Representatives was received by Mr. Novotny, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 292. An act to amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to carry out a pilot program on the use of medical scribes in Department of Veterans Affairs medical centers, and for other purposes.

H.R. 1595. An act to amend title 38, United States Code, to clarify the role of podiatrists in the Department of Veterans Affairs, and for other purposes.

H.R. 1896. An act to amend title 38, United States Code, to require the Secretary of Veterans Affairs to submit an annual report regarding performance awards and bonuses awarded to certain high-level employees of the Department of Veterans Affairs.

H.R. 1848. An act to direct the Secretary of Veterans Affairs to carry out a pilot program on the use of medical scribes in Department of Veterans Affairs medical centers, and for other purposes.

H.R. 2056. An act to amend title 38, United States Code, to improve the procurement practices of the Department of Veterans Affairs, and for other purposes.

H.R. 2333. An act to amend title 38, United States Code, to improve the procurement practices of the Department of Veterans Affairs, and for other purposes.

H.R. 2364. An act to amend the Small Business Investment Act of 1958 to increase the amount of leverage made available to small business investment companies.

H.R. 2749. An act to amend title 38, United States Code, to improve the oversight of contracts awarded by the Secretary of Veterans Affairs to small business concerns owned and controlled by veterans, and for other purposes.

H.R. 2781. An act to direct the Secretary of Veterans Affairs to certify the sufficient participation of small business concerns owned and controlled by veterans and small business concerns owned by veterans with service-connected disabilities in contracts under the Federal Strategic Sourcing Initiative, and for other purposes.

H.R. 3218. An act to amend title 38, United States Code, to make certain improvements in the laws administered by the Secretary of Veterans Affairs, and for other purposes.

The message further announced that the Clerk of the House of Representatives request the Senate to return to the House the joint resolution (H.J. Res. 76) granting the consent and approval of Congress for the Commonwealth of Virginia, the State of Maryland, and the District of Columbia to enter into a compact relating to the establishment of the Washington Metrorail Safety Commission.

At 5:34 p.m., a message from the House of Representatives, delivered by
Mr. Novotny, one of its reading clerks, announced that the House has passed the following joint resolution, in which it requests the concurrence of the Senate:

H.J. Res. 111. Joint resolution providing for congressional approval under chapter 9 of title 5, United States Code, of the rule submitted by the Bureau of Consumer Financial Protection relating to “Arbitration Agreement”.

MEASURES REFERRED

The following bills were read the first and the second time by unanimous consent, and referred as indicated:

H.R. 282. An act to amend the Servicemembers Civil Relief Act to authorize spouses of servicemembers to elect to use the same residences as the servicemembers; to the Committee on Veterans’ Affairs.

H.R. 1058. An act to amend title 38, United States Code, to clarify the role ofoolstatistics in the Department of Veterans Affairs, and for other purposes; to the Committee on Veterans’ Affairs.

H.R. 1690. An act to amend title 38, United States Code, to require the Secretary of Veterans Affairs to submit an annual report regarding performance awards and bonuses awarded to certain high-level employees of the Department of Veterans Affairs; to the Committee on Veterans’ Affairs.

H.R. 1848. An act to direct the Secretary of Veterans Affairs to carry out a pilot program on the use of medical scribes in Department of Veterans Affairs medical centers, and for other purposes; to the Committee on Veterans’ Affairs.

H.R. 2006. An act to amend title 38, United States Code, to improve the procurement practices of the Department of Veterans Affairs, and for other purposes; to the Committee on Veterans’ Affairs.

H.R. 2056. An act to amend the Small Business Act to provide for expanded participation in the microloan program, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H.R. 2361. An act to amend the Small Business Investment Act of 1958 to increase the amount of leverage made available to small business investment companies; to the Committee on Small Business and Entrepreneurship.

H.R. 2436. An act to amend the Small Business Investment Act of 1958 to increase the annual loan limits and purchase limits that small business concerns may invest in small business investment companies, subject to the approval of the appropriate Federal banking agency, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

H.R. 2749. An act to amend title 38, United States Code, to improve the oversight of contractors by the Secretary of Veterans Affairs to small business concerns owned and controlled by veterans, and for other purposes; to the Committee on Veterans’ Affairs.

H.R. 2781. An act to direct the Secretary of Veterans Affairs to certify the sufficient participation of small business concerns owned and controlled by veterans and small business concerns owned by veterans with service-connected disabilities in contracts funded by the Federal Strategic Sourcing Initiative, and for other purposes; to the Committee on Veterans’ Affairs.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–2289. A communication from the Senior Official performing the duties of the Under Secretary of Defense (Acquisition, Technology and Logistics) to the Committee on Armed Services.

EC–2290. A communication from the Acting Assistant Secretary of Defense (Legislative Affairs), transmitting legislative proposals relative to the “Defense Authorization Act for Fiscal Year 2018” to the Committee on Armed Services.

EC–2291. A communication from the General Counsel of Credit Union Administration, transmitting, pursuant to law, the report of a rule entitled “Civil Monetary Penalty Inflation Adjustment” (RIN1318–A587) received in the Office of the President on July 19, 2017; to the Committee on Banking, Housing, and Urban Affairs.

EC–2292. A communication from the Secretary of Commerce, transmitting, pursuant to law, the annual report on the activities of the U.S. Economic Development Administration (EDA) to the Committee on Environment and Public Works.

EC–2293. A communication from the Director of Congressional Affairs, Office of General Counsel, Executive Office of the President, transmitting, pursuant to law, the report of a rule entitled “Revision of Fee Schedules; Fee Recovery for Fiscal Year 2017” (RIN1318–0018) received in the Office of the President on July 13, 2017, to the Committee on Environment and Public Works.

EC–2294. A communication from the Acting Assistant Secretary for Legislation, Department of Health and Human Services, transmitting, pursuant to law, a report entitled “Report to Congress on Ways to Improve Upon the Part D Appeal Process”; to the Committee on Finance.

EC–2295. A communication from the Bureau of Legislative Affairs, Department of State, transmitting, pursuant to section 36(c) of the Arms Export Control Act, the certification of a proposed license for the export of defense articles, including technical data, and defense services to Australia to support the P-8 Production, Sustainment, and Follow-on-Maintenance Program in the amount of $100,000,000 or more (Transmittal No. DDTC 17–042); to the Committee on Foreign Relations.

EC–2296. A communication from the Bureau of Legislative Affairs, Department of State, transmitting, pursuant to section 36(c) of the Arms Export Control Act, the certification of a proposed license for the export of firearms abroad controlled under Section 36(c) of the Arms Export Control Act, the certification of a proposed license for the export of firearms abroad controlled under Category I of the United States Munitions List of pistols to El Salvador in the amount of $1,000,000 or more (Transmittal No. DDTC 16–154); to the Committee on Foreign Relations.

EC–2297. A communication from the Deputy Assistant Secretary of Legislative Affairs, Department of State, transmitting, pursuant to law, a report to Congress from the Chairman of the National Advisory Council on International Monetary and Financial Policies; to the Committee on Foreign Relations.

EC–2298. A communication from the Chief Counsel, Foreign Claims Settlement Commission of the United States, Department of Justice, transmitting, pursuant to law, the Commission’s annual report for 2016; to the Committee on Foreign Relations.

EC–2299. A communication from the Assistant General Counsel for Regulatory Services, Office of General Counsel, Department of Education, transmitting, pursuant to law, the report of a rule entitled “Elementary and Secondary Education Act of 1965, as Amended by the Every Student Succeeds Act of 2015—Grants for Developing, Implementing, and Assessing Accountability Plans” (RIN8180–AB27) (Docket No. ED–2016–0354); to the Committee on Appropriations.

EC–2300. A communication from the Chair, Advisory Council on Alzheimer’s Research, Care, and Services, transmitting, pursuant to law, a report that includes recommendations for improving federally and privately funded Alzheimer’s programs; to the Committee on Health, Education, Labor, and Pensions.

EC–2301. A communication from the Secretary of Education, transmitting, pursuant to law, the report of a rule entitled “Teacher Preparations Issues” (RIN1840–AD07) received in the Office of the President on July 19, 2017, to the Committee on Health, Education, Labor, and Pensions.


EC–2303. A communication from the Acting Assistant Secretary of Defense (Legislative Affairs), transmitting legislative proposals relative to the “National Defense Authorization Act for Fiscal Year 2018”; to the Committee on Homeland Security and Governmental Affairs.

EC–2304. A communication from the Director of Regulation Policy and Management, Department of Veterans Affairs, transmitting, pursuant to law, the report of a rule entitled “VA Veteran-Owned Small Business Verification Guidelines” (RIN2900–AP93) received in the Office of the President on July 19, 2017, to the Committee on Veterans’ Affairs.

EC–2305. A joint communication from the Interim Deputy Secretary of Veterans Affairs, the Senior Official performing the duties of the Under Secretary of Defense (Personnel and Readiness), transmitting, pursuant to law, a report entitled “Veterans Affairs Department Legislative Proposals; and Executive Committee Fiscal Year 2016 Annual Report”; to the Committee on Veterans’ Affairs.

EC–2306. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Standard Instrument Approach Procedures, and Takeoff Minimums and Obstacle Departure Procedures; Miscellaneous Amendments (4); Amdt. No. 3750” (RIN2120–AA65) received in the Office of the President on July 19, 2017, to the Committee on Commerce, Science, and Transportation.

EC–2307. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Standard Instrument Approach Procedures, and Takeoff Minimums and Obstacle Departure Procedures, Miscellaneous Amendments (4); Amdt. No. 3747” (RIN2120–AA65) received in the Office of the President on July 19, 2017, to the Committee on Commerce, Science, and Transportation.

EC–2308. A communication from the Management and Program Analyst, Federal
Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Standard Instrument Approach Procedures, and Takeoff Minima, Departure Clearances, and Termination of Departure Routes; Miscellaneous Amendments (114); Amdt. No. 3749” (RIN2120-AA65) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2309. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; The Boeing Company Airplanes” ((RIN2120-AA64) (Docket No. FAA–2016–3984)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2310. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Airbus Airplanes” ((RIN2120-AA64) (Docket No. FAA–2015–3148)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2311. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Airbus Airplanes” ((RIN2120-AA64) (Docket No. FAA–2016–3984)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2312. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Airbus Airplanes” ((RIN2120-AA64) (Docket No. FAA–2016–3984)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2313. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Airbus Airplanes” ((RIN2120-AA64) (Docket No. FAA–2016–3984)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2314. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Airbus Airplanes” ((RIN2120-AA64) (Docket No. FAA–2016–8185)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2315. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Airbus Airplanes” ((RIN2120-AA64) (Docket No. FAA–2016–3971)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2316. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Airbus Airplanes” ((RIN2120-AA64) (Docket No. FAA–2016–3974)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2317. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Bombardier, Inc. Aircraft Airplanes” ((RIN2120-AA64) (Docket No. FAA–2017–0558)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2318. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; The Boeing Company Airplanes” ((RIN2120-AA64) (Docket No. FAA–2016–3981)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2319. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; The Boeing Company Airplanes” ((RIN2120-AA64) (Docket No. FAA–2016–9188)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2320. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; The Boeing Company Airplanes” ((RIN2120-AA64) (Docket No. FAA–2016–9502)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2321. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; The Boeing Company Airplanes” ((RIN2120-AA64) (Docket No. FAA–2016–9506)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2322. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; The Boeing Company Airplanes” ((RIN2120-AA64) (Docket No. FAA–2016–9561)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2323. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Airbus Helicopters” ((RIN2120-AA64) (Docket No. FAA–2017–0903)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2324. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; The Boeing Company Airplanes” ((RIN2120-AA64) (Docket No. FAA–2015–7529)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2325. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Bombardier, Inc. Aircraft Airplanes” ((RIN2120-AA64) (Docket No. FAA–2017–0558)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2326. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Piper Aircraft, Inc. Airplanes” ((RIN2120-AA64) (Docket No. FAA–2016–2924)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2327. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Bombardier, Inc. Aircraft Airplanes” ((RIN2120-AA64) (Docket No. FAA–2016–2924)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2328. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Gulfstream Aerospace Corporation Airplanes” ((RIN2120-AA64) (Docket No. FAA–2016–9437)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2329. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Bell Helicopter Textron Canada Limited Helicopters” ((RIN2120-AA64) (Docket No. FAA–2017–0861)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2330. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Airbus Helicopters Deutschland GmbH Helicopters” ((RIN2120-AA64) (Docket No. FAA–2017–0861)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2331. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Bombardier, Inc. Aircraft Airplanes” ((RIN2120-AA64) (Docket No. FAA–2017–0558)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2332. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Airbus Helicopters” ((RIN2120-AA64) (Docket No. FAA–2017–0693)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC-2333. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives; Bell Helicopter Textron Canada Limited Helicopters” ((RIN2120-AA64) (Docket No. FAA–2017–0861)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

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Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives; Rolls-Royce plc Turbomfan Engines (Docket No. FAA–2017–0187)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2334. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives; GVG Flugzeugbau GmbH Gilders (Docket No. FAA–2017–0943)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.


EC–2336. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Amendment of and Establishment of Air Traffic Service (ATS) Routes; Northcentral United States (Docket No. FAA–2016–8944)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2337. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Amendment of Class D and E Airspace; Tucson, AZ (RIN2120–AA66) (Docket No. FAA–2017–0218)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2338. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Amendment of Class E Airspace; Hilo, HI (RIN2120–AA66) (Docket No. FAA–2017–0222)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2339. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Amendment of Class E Airspace; Arcata, CA; Fortuna, California (Docket No. FAA–2017–0651)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2340. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Amendment of Class E Airspace; Arcata, CA; Eureka, CA (RIN2120–AA66) (Docket No. FAA–2015–6751)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2341. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Establishment of Class E Airspace; Arcata, CA; and Establishment of Class E Airspace; Arcata, CA; and Establishment of Class E Airspace; Eureka, CA; and Establishment of Class E Airspace; Arcata, CA, and Eureka, CA (RIN2120–AA66) (Docket No. FAA–2015–6751)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2342. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Establishment of Class E Airspace; Sacramento, CA (RIN2120–AA66) (Docket No. FAA–2016–9466) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2343. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Establishment of Class E Airspace; Grayling, AK (RIN2120–AA66) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2344. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Amendment of Class E Airspace; Eugene, OR (RIN2120–AA66) (Docket No. FAA–2017–0224)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2345. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Amendment of Multiple Restricted Areas; Townsend, GA (RIN2120–AA66) (FAA–2017–0650)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2346. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Establishment of Class E Airspace; Hilo, HI (RIN2120–AA66) (Docket No. FAA–2017–0222)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2347. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Establishment of Class E Airspace; Arcata, CA; Fortuna, California (Docket No. FAA–2017–0651)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2348. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Establishment of Class E Airspace; Breakwall and Barge Fireworks Display, Oswego Harbor, Oswego, NY (RIN1625–AA60) (Docket No. USCG–2017–0399)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2349. A communication from the Attorney–Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Safety Zone; Lake Michigan, Whiting, Indiana (RIN1625–AA60) (Docket No. USCG–2017–0195)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2350. A communication from the Attorney–Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Safety Zone; Lake Michigan, Whiting, Indiana (RIN1625–AA60) (Docket No. USCG–2017–0446)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2351. A communication from the Attorney–Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Safety Zone; Port Huron Water Fest Fireworks, St. Clair River, Port Huron, MI (RIN1625–AA60) (Docket No. USCG–2017–0500)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2352. A communication from the Attorney–Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Safety Zone; Potomac River, Montgomery County, MD (RIN1625–AA60) (Docket No. USCG–2017–0446)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2353. A communication from the Attorney–Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Safety Zone; Bay Village Independence Day Fireworks Display; Lake Erie, Lakewood, OH (RIN1625–AA60) (Docket No. USCG–2017–0658)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2354. A communication from the Attorney–Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Safety Zones; Marine Events held in the Captain of the Port Long Island Sound Zone (RIN1625–AA60) (Docket No. USCG–2017–0440)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2355. A communication from the Attorney–Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Safety Zones; Marine Events held in the Captain of the Port Long Island Sound Zone (RIN1625–AA60) (Docket No. USCG–2017–0440)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2356. A communication from the Attorney–Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Safety Zones; Marine Events held in the Captain of the Port Long Island Sound Zone (RIN1625–AA60) (Docket No. USCG–2017–0243)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2357. A communication from the Attorney–Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Safety Zones; Marine Events held in the Captain of the Port Long Island Sound Zone (RIN1625–AA60) (Docket No. USCG–2017–0440)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.
of Homeland Security, transmitting, pursuant to law, the report of a rule entitled “Safety Zone; St. Ignace Fireworks Displays, St. Ignace, MI” (RIN1625–AA00) (Docket No. USCIG–2017–0331) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2386. A communication from the Vice President of Government Affairs and Corporate Communications, National Railroad Passengers Corporation, Amtrak, transmitting, pursuant to law, the report of a rule entitled “Competitive Passenger Pilot Program” (RIN2130–AC60) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2386. A communication from the Acting Chairman of the Office of Proceedings, Surface Transportation Board, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Offers of Financial Assistance” (RIN2140–AR27) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

PETITIONS AND MEMORIALS

The following petitions and memorials were laid before the Senate and were referred or ordered to lie on the table as indicated.

POM–76. A resolution adopted by the House of Representatives of the State of Michigan urging the United States Congress to continue full funding for the Facility for Rare Isotope Beams on the campus of Michigan State University; to the Committee on Commerce, Science, and Transportation.

HOUSE RESOLUTION NO. 113

Resolved, That this application constitutes a continuing application in accordance with art. V, Constitution of the United States, until at least two-thirds of the legislatures of the several states have applied for a similar convention of the states; and be it further

Resolved, That this application constitutes a continuing application in accordance with art. V, Constitution of the United States; and be it further

Resolved, That this application constitutes a continuing application in accordance with art. V, Constitution of the United States; and be it further

EXECUTIVE REPORTS OF COMMITTEE

The following executive reports of nominations were submitted:

By Mr. BURR for the Select Committee on Intelligence:

Robert F. Storch, of the District of Columbia, to be Inspector General of the National Security Agency.

By Marie Keenan Patelunas, of Pennsylvania, to be Assistant Secretary for Intelligence and Analysis, Department of the Treasury.

By Mr. Gordon, of Virginia, to be Principal Deputy Director of National Intelligence.
ADDITIONAL COSPONSORS

S. 170

At the request of Mr. RUBIO, the name of the Senator from Colorado (Mr. GARDNER) and the Senator from Massachusetts (Mr. MARKEY) were added as cosponsors of S. 170, a bill to provide for nonpreemption of measures by State and local governments to divest from entities that engage in commerce-related or investment-related divestment, or sanctions activities targeting Israel, and for other purposes.

S. 259

At the request of Mr. NELSON, the name of the Senator from North Carolina (Mr. BURR) was added as a cosponsor of S. 259, a bill to modify the prohibition on recognition by United States courts of certain rights relating to certain marks, trade names, or commercial names.

S. 266

At the request of Mr. HATCH, the name of the Senator from South Dakota (Mr. ROBERTS) was added as a cosponsor of S. 266, a bill to award the Congressional Gold Medal to Anwar Sadat recognition of his heroic achievements and courageous contributions to peace in the Middle East.

S. 372

At the request of Mr. PORTMAN, the name of the Senator from Virginia (Mr. Kaine) was added as a cosponsor of S. 372, a bill to amend the Tariff Act of 1930 to ensure that merchandise arriving through the mail shall be subject to review by U.S. Customs and Border Protection and to require the provision of advance electronic information on shipments of mail to U.S. Customs and Border Protection and for other purposes.

S. 407

At the request of Mr. CRAPO, the name of the Senator from Maryland (Mr. Van HOLLEN) was added as a cosponsor of S. 407, a bill to amend the Internal Revenue Code of 1986 to permanently extend the railroad track maintenance credit.

S. 415

At the request of Mr. CARDIN, the name of the Senator from New Jersey (Mr. BOOKER) was added as a cosponsor of S. 445, a bill to amend title XVIII of the Social Security Act to ensure more timely access to home health services for Medicare beneficiaries under the Medicare program.

S. 448

At the request of Mr. BROWN, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 448, a bill to amend title XVIII of the Social Security Act to provide for treatment of clinical psychologists as physicians for purposes of furnishing clinical psychologist services under the Medicare program.

S. 474

At the request of Mr. GRAHAM, the name of the Senator from Texas (Mr. CORNYN) was added as a cosponsor of S. 474, a bill to condition assistance to the West Bank and Gaza on steps by the Palestinian Authority to end violence and terrorism against Israeli citizens.

S. 602

At the request of Ms. COLLINS, the names of the Senator from Michigan (Mr. PETERS) and the Senator from South Carolina (Mr. GRAHAM) were added as cosponsors of S. 602, a bill to amend the Internal Revenue Code of 1986 to include automated fire sprinkler system retrofits as section 179 property and classify certain automated fire sprinkler system retrofits as 15-year property for purposes of depreciation.

S. 654

At the request of Mr. TOOMEY, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 654, a bill to revise section 48 of title 18, United States Code, and for other purposes.

S. 720

At the request of Mr. PORTMAN, the name of the Senator from Louisiana (Mr. KENNEDY) was added as a cosponsor of S. 720, a bill to amend the Export Administration Act of 1979 to include in the prohibitions on boycotts against allies of the United States boycotts fostered by international governmental organizations against Israel and to direct the Export-Import Bank of the United States to oppose boycotts against Israel, and for other purposes.

S. 822

At the request of Mr. INHOFE, the name of the Senator from Massachusettas (Mr. WARREN) was added as a cosponsor of S. 822, a bill to amend the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 to modify provisions relating to grants, and for other purposes.

S. 1002

At the request of Mr. MORAN, the name of the Senator from Nebraska (Mrs. FISCHER) was added as a cosponsor of S. 1002, a bill to enhance the ability of community financial institutions to lend to communities with high concentrations of child poverty and to serve their communities, boost small businesses, increase individual savings, and for other purposes.

S. 1019

At the request of Mr. CRUZ, the name of the Senator from North Carolina (Mr. TILLIS) was added as a cosponsor of S. 1019, a bill to provide humanitarian assistance for the Venezuelian people, to defend democratic governance and combat widespread public corruption in Venezuela, and for other purposes.

S. 1196

At the request of Mrs. SHAHEEN, the name of the Senator from Michigan...
S. 1630
At the request of Mr. Cotton, the name of the Senator from Florida (Mr. Rubio) was added as a cosponsor of S. 1630, a bill to enhance the security of Taiwan and bolster its participation in the international community, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS
By Mr. Udall (for himself, Mr. Blumenthal, Mr. Booker, Mr. Durbin, Mrs. Gillibrand, Mr. Merkley, Ms. Harris, Mr. Cardin, and Mr. Warner):
S. 1624. A bill to prohibit the use of chlorpyrifos on food, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. Udall. Mr. President, I ask unanimous consent that the text of the bill be printed in the Record.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

SEC. 2. FINDINGS.
Congress finds as follows:
(1) In 1996, Congress unanimously passed the Food Quality Protection Act of 1996 (Public Law 104-170; 110 Stat. 1489) (referred to in this section as "FQPA"), a comprehensive overhaul of Federal pesticide and food safety policy. That Act amended the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136 et seq.), the laws that govern how the Environmental Protection Agency (referred to in this section as the "EPA") registers pesticides and pesticide labels for use in the United States and establishes tolerances or acceptable levels for pesticide residues on food.

(2) The FQPA directs the EPA to ensure with "reasonable certainty" that "no harm" will result from food, drink, and other exposures to a pesticide. If EPA cannot make this safety finding, it must prohibit residues and use of the pesticide on food. The FQPA mandates that EPA must consider children's special sensitivity and exposure to pesticide chemicals and must make an explicit determination that the pesticide can be used with a "reasonable certainty of no harm" to children. In determining acceptable levels of pesticide residue, EPA must account for the potential health harm from postnatal exposure to a pesticide or economic benefits of pesticides cannot be used to over-ride this health-based standard for children from food and other exposures.

(3) Chlorpyrifos is a widely used pesticide first registered by EPA in 1965. Chlorpyrifos is an organophosphate pesticide, a class of pesticides developed as nerve agents in World War II and adapted for use as insecticides after the war. Chlorpyrifos and other organophosphate pesticides affect the nervous system through inhibition of cholinesterase, an enzyme required for proper nerve functioning. Acute poisonings occur when nerve impulses pulsate through the...
body, causing symptoms like nausea, vomiting, convulsions, respiratory paralysis, and, in extreme cases, death. Based on dozens of peer-reviewed scientific articles, EPA determined exposure during pregnancy to even low levels of chlorpyrifos that caused only minimal cholinesterase inhibition (10 percent or less) in the mothers could lead to measurable long-lasting delays in motor development, attention-deficit disorders, and structural changes in the brain.

(5) Chlorpyrifos is acutely toxic and associated with neurodevelopmental harms in children. Prenatal exposure to chlorpyrifos is associated with elevated risks of reduced IQ, loss of motor ability, delays in motor development, attention-deficit disorders, and structural changes in the brain.

(6) Chlorpyrifos has long been of concern to EPA. Residential uses of chlorpyrifos ended in 2000 after EPA found unsafe exposures to children. EPA also discontinued use of chlorpyrifos in 2016 to protect drinking water contamination, which would maintain no-spray buffers around schools, communities, schools, playfields, day cares, hospitals, and other public places, ranging from 10 to 100 feet away. EPA's 2014 and 2016 risk assessments have been completed and submitted to the Administrator not later than October 1, 2019.

(7) In its 2016 report, the Federal Insecticide, Fungicide, and Rodenticide Act Scientific Advisory Panel recognized "the growing body of literature with laboratory animals (rats and mice) indicating that gestational and early postnatal exposure to chlorpyrifos may cause persistent effects into adulthood along with epidemiology studies which have evaluated prenatal chlorpyrifos exposure in mother-infant pairs and reported associations with neurodevelopment outcomes in infants and children.

(8) Chlorpyrifos threatens the healthy development of children. Children experience greater exposure to chlorpyrifos and other pesticides because they are more likely to eat and drink more proportional to their body weight. A growing body of evidence shows that prenatal exposure to very low levels of chlorpyrifos may lead to lasting and possibly permanent neurological impairments. In November 2016, EPA released a revised human health risk assessment for chlorpyrifos indicating that there are no acceptable uses for the pesticide, all food uses exceed acceptable levels, with children ages 1 to 2 exposed to levels of chlorpyrifos that are 140 times what the EPA considers acceptable.

(9) Chlorpyrifos threatens the healthy development of children. Children experience greater exposure to chlorpyrifos and other pesticides because they are more likely to eat and drink more proportional to their body weight. A growing body of evidence shows that prenatal exposure to very low levels of chlorpyrifos may lead to lasting and possibly permanent neurological impairments. In November 2016, EPA released a revised human health risk assessment for chlorpyrifos indicating that there are no acceptable uses for the pesticide, all food uses exceed acceptable levels, with children in the food primarily as a result of the metabolism or other degradation of chlorpyrifos.''.

SEC. 4. REVIEW OF ORGANOPHOSPHATE PESTICIDES.

(a) In General.—Not later than 90 days after the date of enactment of this Act, the Administrator of the Environmental Protection Agency shall enter into a contract with the National Research Council to conduct a cumulative and aggregate assessment of the health impacts of chlorpyrifos on agricultural communities. Rural families are exposed to unsafe levels of the pesticide even with maximum personal protective equipment and engineering controls. Field workers are currently allowed to re-enter fields within 1 to 5 days after chlorpyrifos is sprayed based on current restricted entry intervals on the registered chlorpyrifos labels but unsafe exposures continue on average 18 days after applications.

(11) Chlorpyrifos threatens the healthy development of children. Children experience greater exposure to chlorpyrifos and other pesticides because they are more likely to eat and drink more proportional to their body weight. A growing body of evidence shows that prenatal exposure to very low levels of chlorpyrifos may lead to lasting and possibly permanent neurological impairments. In November 2016, EPA released a revised human health risk assessment for chlorpyrifos indicating that there are no acceptable uses for the pesticide, all food uses exceed acceptable levels, with children ages 1 to 2 exposed to levels of chlorpyrifos that are 140 times what the EPA considers acceptable.

(b) CONSIDERATIONS.—The review under subsection (a) shall—

(1) assess the neurodevelopmental effects and other low-dose effects of exposure to organophosphate pesticides, including in the most vulnerable subpopulations, including—

(A) the prenatal, childhood, adolescent, and early life stages; and

(B) agricultural workers;

(2) assess the cumulative and aggregate risks from exposure described in paragraph (1) to ensure that children, including infants, children, and fetuses, of exposure to organophosphate pesticides, including in the most vulnerable subpopulations, including—

(A) the prenatal, childhood, adolescent, and early life stages; and

(B) agricultural workers;

(3) be completed and submitted to the Administrator not later than October 1, 2019.

(b) REGULATORY ACTION.—

(1) APPLICABILITY.—This subsection shall apply if the Administrator becomes aware of any exposure to any organophosphate pesticide, including exposures described in paragraphs (1) and (2) of subsection (b), that does not meet, as applicable—

(A) the standard under section 408(b)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 346a(b)(2)); or

(B) any standard under the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136 et seq.).

(2) ACTION.—Not later than 90 days after the date on which the Administrator becomes aware of any exposure under paragraph (1), the Administrator shall take any appropriate regulatory action, regardless of whether the review under subsection (a) is completed, including—

(A) revocation or modification of a toler- ance under section 408 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 346a); or

(B) modification, cancellation, or suspension of a registration under the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136 et seq.).

(d) EFFECT.—Nothing in this section authorizes or requires the Administrator to delay in carrying out or completing, with respect to an organophosphate pesticide, any registration review under section 3(g) of the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136a(g)), any toler- ance review under section 408 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 346a), or any registration or modification, cancellation, or suspension of a registration under section 3 or 6 of the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136a, 136d).

(13) In 2015, leading scientific and medical experts from both the United States and abroad came together, under “Project TENDR: Targeting Environmental Neuro-Developmental Risks” (referred to in this section as TENDR), to call for action to reduce widespread exposures to chemicals that interfere with fetal and children’s brain development. Based on the available and peer-reviewed scientific evidence, the TENDR authors identified prime examples of neurodevelopmentally toxic chemicals “that can contribute to learning, behavioral, or intellectual impairment in specific children with disabilities, including—but not limited to—the highest number of pesticide poisoning incidents, which would allow EPA to enter into a contract with the National Research Council to conduct a cumulative and aggregate assessment of the health impacts of chlorpyrifos on agricultural communities. Rural families are exposed to unsafe levels of the pesticide even with maximum personal protective equipment and engineering controls. Field workers are currently allowed to re-enter fields within 1 to 5 days after chlorpyrifos is sprayed based on current restricted entry intervals on the registered chlorpyrifos labels but unsafe exposures continue on average 18 days after applications.

(14) In its 2016 report, the Federal Insecticide, Fungicide, and Rodenticide Act Scientific Advisory Panel recognized "the growing body of literature with laboratory animals (rats and mice) indicating that gestational and early postnatal exposure to chlorpyrifos may cause persistent effects into adulthood along with epidemiology studies which have evaluated prenatal chlorpyrifos exposure in mother-infant pairs and reported associations with neurodevelopment outcomes in infants and children.

(15) In 2015, leading scientific and medical experts from both the United States and abroad came together, under “Project TENDR: Targeting Environmental Neuro-Developmental Risks” (referred to in this section as TENDR), to call for action to reduce widespread exposures to chemicals that interfere with fetal and children’s brain development. Based on the available and peer-reviewed scientific evidence, the TENDR authors identified prime examples of neurodevelopmentally toxic chemicals “that can contribute to learning, behavioral, or intellectual impairment in specific children with disabilities, including—but not limited to—the highest number of pesticide poisoning incidents, which would allow EPA to enter into a contract with the National Research Council to conduct a cumulative and aggregate assessment of the health impacts of chlorpyrifos on agricultural communities. Rural families are exposed to unsafe levels of the pesticide even with maximum personal protective equipment and engineering controls. Field workers are currently allowed to re-enter fields within 1 to 5 days after chlorpyrifos is sprayed based on current restricted entry intervals on the registered chlorpyrifos labels but unsafe exposures continue on average 18 days after applications.

(16) In its 2016 report, the Federal Insecticide, Fungicide, and Rodenticide Act Scientific Advisory Panel recognized "the growing body of literature with laboratory animals (rats and mice) indicating that gestational and early postnatal exposure to chlorpyrifos may cause persistent effects into adulthood along with epidemiology studies which have evaluated prenatal chlorpyrifos exposure in mother-infant pairs and reported associations with neurodevelopment outcomes in infants and children.

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(20) In its 2016 report, the Federal Insecticide, Fungicide, and Rodenticide Act Scientific Advisory Panel recognized "the growing body of literature with laboratory animals (rats and mice) indicating that gestational and early postnatal exposure to chlorpyrifos may cause persistent effects into adulthood along with epidemiology studies which have evaluated prenatal chlorpyrifos exposure in mother-infant pairs and reported associations with neurodevelopment outcomes in infants and children.

By Mr. REED (for himself, Mr. Rounds, Mr. Brown, Ms. Collins, Mr. Carper, Mr. Coons,
The impact of cancelling DEPSCoR went far beyond research grants. Developing university research capabilities in all 50 States is critical to meeting DoD workforce needs. The Defense Laboratory Enterprise is more national in scope than NASA or the Department of Energy’s National Laboratory system, with facilities in 24 States, including DEPSCoR-eligible States. The 2016 review of DoD laboratories by the Defense Science Board reported that these laboratories depend on locally trained scientists. Without relevant training provided through DoD-supported research projects at nearby universities, these facilities may struggle to find highly qualified scientists and engineers.

Because of these concerns, I have been working with my colleague on the Armed Services Committee, Senator ROUNDS of South Dakota, to revive this program. This reauthorization uses the lessons learned from the previous iteration of DEPSCoR to improve the program, making it more responsive to Department of Defense needs.

I invite our colleagues to join us in supporting this legislation.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 231—DESIGNATING JULY 30, 2017, AS ‘‘NATIONAL WHISTLEBLOWER APPRECIATION DAY’’

Mr. GRASSLEY (for himself, Mr. JOHNSON, Ms. BALDWIN, Mr. CARPER, Mr. WYDEN, Mr. MARKET, Mr. BOOZMAN, Mrs. MCCASKILL, Mr. TILLIS, Mrs. ERNST, Mrs. FISCHER, Mr. PETERS, and Mrs. FEINSTEIN) submitted the following resolution; which was referred to the Committee on the Judiciary:

Whereas, in 1777, before the passage of the Bill of Rights, 10 sailors and marines blew the whistle on misconduct that was harmful to the United States;

Whereas the Founding Fathers unanimously supported the whistleblowers in words and deeds, including by releasing government records and providing monetary assistance for the reasonable legal expenses necessary to prevent retaliation against the whistleblowers;

Whereas, on July 30, 1778, in demonstration of their full support for whistleblowers, the members of the Continental Congress unani mously adopted the Whistleblower legislation in the United States that read: ‘‘Resolved, That it is the duty of all persons in the service of the United States, as well as all other persons, to give the earliest information to Congress or other proper authority of any misconduct, frauds or misdemeanors committed by any officers or persons in the service of these states, which may come to their knowledge’’ (legislation of July 30, 1778, reprinted in Journals of the Continental Congress, 1774–1789, ed. Worthington Chauncey Gilmor et al. (Washington, D.C., 1904–37), 11:732);

Whereas whistleblowers risk their careers, jobs, and reputations by reporting waste, fraud, and misconduct, and face discrimination, retaliation, and other forms of retribution;

Whereas, in providing the proper authorities with lawful disclosures, whistleblowers save the taxpayers of the United States billions of dollars each year and serve the public interest by ensuring that the United States remains an ethical and safe place; and

Whereas it is the expressed intent of the United States to encourage, in accordance with Federal law (including the Constitution of the United States, rules, and regulations) the responsible disclosure of classified information (including sources and methods of detection of classified information), honest and good faith reporting of misconduct, fraud, misdemeanors, and other crimes to the appropriate authority at the earliest time possible; Now, therefore, be it

Resolved, That the Senate—

(a) designates July 30, 2017, as ‘‘National Whistleblower Appreciation Day’’; and

(b) ensures that the Federal Government implements the intent of the Founding Fathers, for military construction, and for defense activities of the Department of Energy, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for each fiscal year, and for other purposes; which was ordered to lie on the table.

SA 263. Mrs. SHAHEEN 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 each fiscal year, and for other purposes; which was ordered to lie on the table.

SA 264. Mr. McCAIN 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 each fiscal year, and for other purposes; which was ordered to lie on the table.

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.

SA 266. Mr. McCAIN submitted an amendment intended to be proposed by him to the bill H.R. 1628, which was ordered to lie on the table.

SA 267. Mr. McCONNELL proposed an amendment to the bill H.R. 1628, supra.

SA 268. Mr. WHITEHOUSE 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 269. Mr. REED (for himself, Mr. ROUNDS, Mr. BROWN, Ms. COLLINS, Mr. CARPER, Mr. COONS, Mr. WHITEHOUSE, Ms. SHAHEEN, Ms. CORTEZ MASTO, and Ms. HIRONO) 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 each fiscal year, and for other purposes; which was ordered to lie on the table.
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 American Taxpayer Relief Act of 2012 for fiscal year 2013, for the military and diplomatic strategies of the United States with respect to the conflict in Syria. (c) COMPOSITION.—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 Senate; (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; (I) One member appointed by amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table. SA 271. Ms. DUCKWORTH 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 272. Mr. PAUL 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 273. Mr. JOHNSON 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 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. HARRIS, Ms. SMITH, Mr. WARNER, Ms. HERTKAMP, 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. 2340, to authorize appropriations for fiscal year 2018 for defense 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. 2340, 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 Concurrent 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: At the end of subtitle C of title XII, add the following: 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") 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: (A) One member appointed by the chair of the Senate Committee on Armed Services; (B) One member appointed by the ranking minority member of the Senate Committee on Armed Services; (C) One member appointed by the chair of the Senate Committee on Foreign Relations; (D) One member appointed by the ranking minority member of the Senate Committee on Foreign Relations; (E) One member appointed by the chair of the House Committee on Armed Services; (F) One member appointed by the ranking minority member of the House Committee on Armed Services; (G) One member appointed by the chair of the House Committee on Foreign Affairs; (H) One member appointed by the ranking minority member of the House Committee on Foreign Affairs; (I) One member appointed by amendment SA 267 proposed by Mr. MCCONNELL to the bill S. 1519, supra; which was ordered to lie on the table. (3) PERIOD OF APPOINTMENT; VACANCIES.—Members shall be appointed for the life of the Group, and shall be eligible to serve more than one term. The Group shall be filled in the same manner as the original appointment. (4) DUTIES.— (a) The Group shall receive the full and timely cooperation of the Secretary of Defense, the Secretary of State, and the Director of National Intelligence in providing the Group with analyses, briefings, and other information necessary for the discharge of the duties of the Group. (b) The Group shall (i) examine and make recommendations with respect to the military and diplomatic strategy of the United States with respect to the conflict in Syria, including (I) geopolitical threats to the United States, its allies, and regional and international interests; (II) the current situation in Syria, its impact on the United States and other countries in the region, and potential geopolitical, humanitarian, and economic situation in Syria; (III) the impact of применяте organizations to serve as a liaison officer to the Group. (f) REPORT.—(1) 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: (A) Assess the current security, political, humanitarian, and economic situation in Syria. (B) Assess the current participation and objectives of various external actors in Syria. (C) Assess the consequences of continued conflict in Syria. (D) 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. (E) Provide a strategy for a United States and coalition strategy to reestablish security and governance in Syria, including recommendations for steps to be taken to stabilize, develop, counterterrorism, and reconstruction efforts. (F) Address any other matters with respect to the conflict in Syria that the Group considers appropriate. (2) INTERIM BRIEFING.—Not later than June 30, 2018, the Group shall provide to the Committees 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. (3) FORM OF REPORT.—The report submitted to Congress under paragraph (1) shall be submitted in unclassified form, but may include a classified annex. (g) FACILITATION.—The United States Institute of Peace shall take appropriate actions to facilitate the Group in the discharge of its duties under this section. (h) Term.—The Group shall terminate six months after the date on which it submits the report required by subsection (f)(1). (1) FUNDING.—Of the amounts authorized to be appropriated for fiscal year 2018 for the Department of Defense by this Act, $1,500,000 is available to fund the activities of the Group. SA 263. Mrs. SHAHEEN 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: At the end of subtitle G of title X of division A, insert after section 1070 the following: SEC. 1088. FOREIGN AGENTS REGISTRATION. (a) SHORT TITLE.—This section may be cited as the "Foreign Agents Registration Act Amendment and the Foreign Agents Registration Act Reauthorization Act of 2018". (b) CIVIL INVESTIGATIVE DEMAND AUTHORITY.—The Foreign Agents Registration Act of 1938 (22 U.S.C. 611 et seq.) is amended—
(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 enterprise, or any property subject to jurisdiction of any court of the United States in aid of a grand jury investigation of such alleged violation; or by an agent of a foreign principal as part of the identification of-

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

"(b) require the production of any documentary evidence that would be privileged or otherwise protected from disclosure under law applicable to such violation in a grand jury investigation and the provision of law applicable to such violation; or

"(c) 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 a grand jury investigation of such alleged violation; or

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

"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 a 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;"

"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 readily 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.

"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 a 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;"

"C. INFORMATIONAL MATERIALS.—

"(1) DEFINITIONS.—Section 1 of the Foreign Agents Registration Act of 1938, as amended (22 U.S.C. 611) is amended—

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

"(B) by inserting after subsection (i) the following:

"(1) the term ‘informational materials’ means, graphic, written, or pictorial information or matter of any kind, including matter published by means of advertising, books, periodicals, newspapers, lectures, broadcasts, motion pictures, or any means or instrumentality of interstate or foreign commerce or otherwise.

"(2) INFORMATIONAL MATERIALS.—Section 4 of the Foreign Agents Registration Act of 1938, as amended (22 U.S.C. 614) is amended—

"(A) in subsection (a)—

"(i) by inserting ‘‘, including electronic mail and social media,’’ after ‘‘United States mails and’’;

"(ii) by striking ‘‘, not later than forty-eight hours after the beginning of the transmittal thereof, file with the Attorney General by telephone, wire, radio, telegraph, or by any other means or instrumentality of interstate or foreign commerce or otherwise.’’;

"(B) the Secretary of State, for calendar quarters (or portions of calendar quarters) after 2029, and, in the case of any other State, for calendar quarters after 2029.''; and

"(C) by adding after and below subparagraph (A) the following:

"70 percent for calendar quarters in 2020;

"72 percent for calendar quarters in 2021;

"74 percent for calendar quarters in 2022;

"76 percent for calendar quarters in 2023;

"78 percent for calendar quarters in 2024;

"80 percent for calendar quarters in 2025;

"80 percent for calendar quarters in 2026; and

"82 percent for calendar quarters in 2027; and

"84 percent for calendar quarters in 2028.

"(D) REPORTS TO CONGRESS.—Section 12 of the Foreign Agents Registration Act of 1938, as amended, as redesignated by subsection (b)(1), is amended to read as follows:

"SEC. 12. The Assistant Attorney General for National Security, through the FARA Registration Unit of the National Security Division, shall submit a semiannual report to Congress concerning the activities of this Act. Each report under this section shall include, for the applicable reporting period, the identification of—

"(1) registrations filed pursuant to this Act;

"(2) the nature, sources, and content of political propaganda disseminated and distributed by agents of foreign principal;

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

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

"SA 264. 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 41, strike lines 9 through 16 and insert the following:

"(II) in subparagraph (B) of clause (iii), the following sentence:

"The Federal medical assistance percentage determined for a State and year under subsection (b) shall apply to expenditures for medical assistance to newly eligible individuals (as described) and expansion enrollees (as defined), in the case of a State that has elected to cover newly eligible individuals before March 1, 2017, for calendar quarters after 2029, and, in the case of any other State, for calendar quarters (or portions of calendar quarters) after February 28, 2017; and

SA 267. Mr. MCCONNELL proposed an amendment 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; as follows:

"(II) by inserting subclause (V), (VI), and (VII).
S4198

CONGRESSIONAL RECORD — SENATE

July 25, 2017

Strike all after the first word and insert the following:

1. SHORT TITLE.
This Act may be cited as the “Obamacare Repeal Reconciliation Act of 2017”.

SEC. 101. RECAPTURE EXCESS ADVANCE PAYMENTS OF PREMIUM TAX CREDITS.

(a) Premium Tax Credit.—

(1) REPEAL.—

(A) IN GENERAL.—Subpart (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, 2019.’’.

(b) Effectiveness Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2019.

(c) Definitions.—In this section:

(1) PROHIBITED ENTITY.—The term ‘‘prohibited entity’’ means an entity, including its affiliates, subsidiaries, successors, and clinics—

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

(i) is an organization described in section 501(c)(9) 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 45C of the Public Health Service Act;

(iii) is an organization described in section 501(c)(1) of the Internal Revenue Code of 1986 that is primarily engaged in family planning services, reproductive health, and related medical care; and

(iv) is an organization described in section 501(c)(2) of the Internal Revenue Code of 1986 that is primarily engaged in family planning services, reproductive health, and related medical care;

(2) Effective Date.—The amendments made by subsection (c) shall apply to taxable years beginning after December 31, 2019.

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) Effectiveness Date.—The amendment made by this paragraph shall apply 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 1411 (other than subsection (l)), the last sentence of subsection (o)(4)(A)(ii), and such provisions of such section solely to the extent related to the application of the last sentence of section (o)(4)(A)(ii).

(B) Section 1412.

(2) Effective Date.—The repeal in paragraphs (1) shall take effect on January 1, 2020.

SEC. 103. SMALL BUSINESS TAX CREDIT.

(a) SUNSET.—

(1) IN GENERAL.—Section 500A(c) 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 paragraph (1) shall take effect on January 1, 2020.

SEC. 104. INDIVIDUAL MANDATE.

(a) IN GENERAL.—Section 1512 of the Internal Revenue Code of 1986 is amended by striking subsection (e)(4)(A)(ii), by inserting ''($0 in the case of months beginning after December 31, 2015)'' after ''$2,000''.

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

(c) Definitions.—In this section:

(1) HSA S.—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.

(b) Archer MSAS.—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) Subsequent Effective Date.—The amendments made by subsection (b) 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 never been enacted.

SEC. 105. EMPLOYER MANDATE.

(a) IN GENERAL.—

(1) Paragraph (i) of section 4980B(b) of the Internal Revenue Code of 1986 is amended by inserting ``the amount paid or incurred in taxable years beginning after December 31, 2015'’ after ``$3,000''.

(b) Effectiveness 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 501(a), 1902(a)(23), 1903(a), 2002, 2005(a)(4), and 2056 of the Social Security Act (42 U.S.C. 704(a), 1396a(a)(23), 1396b(a), 1397a(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 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n(a)), 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 payments to a prohibited entity, whether made directly to the prohibited entity or through a managed care organization under contract with the prohibited entity, shall be available to a State for payments to a prohibited entity, whether made directly to the prohibited entity or through a managed care organization under contract with the prohibited entity.

(b) Effectiveness Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2019.

(c) Repeal of Eligibility Determinations.—

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

(2) Reimbursements.—The amendment made by this subsection shall apply to amounts paid or incurred in taxable years beginning after December 31, 2019.

(d) Effectiveness Date.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2019.

(e) Severability.—If any provision of this subsection or the application thereof to any person or circumstances is held invalid, such provision shall be effective only to the extent that it does not affect the validity of the remainder of this subsection.

SEC. 107. MEDICAID.

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

(1) in section 1902—

(A) in subsection (a)(10)(A), by striking ``2.5 percent'' and inserting ``5 percent'', and

(B) in paragraph (3)—

(A) by striking ``(10)'' and inserting ``(20)'' 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. 108. REPEAL OF DISH ALLLOTMENT REDUCIONS.

(a) DISCOUNTS.—Section 36B of the Internal Revenue Code of 1986 is amended by striking paragraphs (7) and (8).

(b) Effectiveness Date.—The amendments made by subsection (a) shall apply to taxable years beginning after December 31, 2019.

(c) Subsequent Effective Date.—The amendments 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 never been enacted.

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 amendments 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 never been enacted.

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

(a) HSA S.—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.—Section 108 of the Internal Revenue Code of 1986 is amended by striking “Such term” and all that follows through the period.

(d) EFFECTIVE DATE.—The amendments made by subsection (c) shall apply to employer health insurance premium taxes assessed after December 31, 2016.

(e) Reimbursements.—The amendments made by subsection (c) shall apply to amounts paid with respect to taxable years beginning after December 31, 2016.

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

(a) HSA S.—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 amounts paid with respect to taxable years beginning after December 31, 2016.

SEC. 112. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO FLEXIBLE SPENDING ACCOUNTS.

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

(b) Archer MSAS.—Section 223(b)(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 amounts paid with respect to taxable years beginning after December 31, 2016.
Subsection (j) of section 9008 of the Patient Protection and Affordable Care Act is amended by adding at the end the following new subsection:

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

"The credit for the expense allocable to the purchase of health insurance shall be allowed under this subsection (and shall be limited to the amount permitted to be taken into account under such section) only if the taxpayer was an individual with respect to whom the otherwise allowable deduction for the tax year was not so taken into account because it was necessary to do so in order to avoid a decrease in the amount of the deduction permitted for the tax year.""
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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. 300–a1–1) is amended—

(1) in paragraph (3), by striking "each of fiscal years 2018 and 2019" and inserting "fiscal year 2018";

(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 an amount equal to 2.9 percent of the bond proceeds held in the Treasury on December 31, 2019, 2020, and 2021, and of the amount held thereafter, to remain available until expended.

(b) USE OF FUNDS.—Grants awarded to States under subsection (a) shall be used for the following purposes—

(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 providers to appropriate health care providers to treat substance use disorders or mental health needs.

(5) Other public health-related activities, as determined by the Secretary, 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.""
the debtor's aggregate interest, not to exceed $250,000 in value, in property described in paragraph (4) of title 11, United States Code, is amended by inserting the following new paragraph (4):

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

(2) CONFORMING AMENDMENTS.—Section 104 of title 11, United States Code, is amended—

(A) in subsection (a), in the matter preceding paragraph (1), by inserting “$222(r),” after “$222(q),”;

(B) in subsection (b), by inserting “$222(r),” after “$220,”;

(c) WAIVER OF ADMINISTRATIVE REQUIREMENTS.—

(1) CASE UNDER CHAPTER 7.—Section 707(b) of title 11, United States Code, is amended by adding at the end the following:

“(8) Paragraph (2) applies only with respect to cases commenced on or after the date of enactment of this Act.

(2) CASE UNDER CHAPTER 13.—Section 1325(b)(1) of title 11, United States Code, is amended—

(A) in subparagraph (A), by striking “or” at the end;

(B) in subparagraph (B), by striking the period at the end and inserting a comma; and

(C) by adding at the end the following:

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

(3) CASE UNDER CHAPTER 11.—Section 1123(b)(1) of title 11, United States Code, is amended—

(A) in subparagraph (A), by striking “or” at the end;

(B) in subparagraph (B), by striking the period at the end and inserting a comma; and

(C) by adding at the end the following:

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

(d) CREDIT COUNSELING.—Section 109(h)(4) of title 11, United States Code, is amended by inserting “a medically distressed debtor or” after “apply with respect to”.

(e) STUDENT LOAN UNDER HARDSHIP.—Section 523(a)(8) of title 11, United States Code, is amended by inserting “the debtor is a medically distressed debtor or” before “excepting.”

(f) ATTESTATION BY DEBTOR.—Section 521 of title 11, United States Code, is amended by adding at the end the following:

“(k) If the debtor seeks relief as a medically distressed debtor, the debtor shall file a statement of medical expenses relevant to the determination of whether the debtor is a medically distressed debtor, which statement shall declare under penalty of perjury that such medical expenses were not incurred for the purpose of bringing the debtor within the meaning of the term medically distressed debtor.”.

(g) EFFECTIVE DATE; APPLICATION OF AMENDMENTS.—

(1) EFFECTIVE DATE.—Except as provided in paragraph (2), this section and the amendments made by this section shall take effect on the date of enactment of this Act.

(2) APPLICATION OF AMENDMENTS.—The amendments made by this section shall apply only with respect to cases commenced under title 11, United States Code, on or after the date of enactment of this Act.

SA 269. Mr. REED (for himself, Mr. ROUNDS, Ms. COLLINS, Mr. CARPER, Mr. COONS, Mr. WHITERHEAD, Mrs. SHAHEEN, Ms. Cortez Masto, and Ms. HIRONO) submitted an amendment intended to be proposed by him 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 appropriate place in Subtitle B of title II, insert the following:

SEC. 2. REAUTHORIZATION OF DEPARTMENT OF DEFENSE'S PROGRAM TO STIMULATE COMPETITIVE RESEARCH.

(a) MODIFICATION 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. 2308 note) is amended—

(1) by redesigning 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;”;

(3) in paragraph (3), as redesignated by paragraph (1), by inserting “relevant to the mission of the Department of Defense” after “that is”.

(b) MODIFICATION 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 community connections with Department of Defense laboratories and such researchers.”.

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

(1) in paragraph (2)(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 designation made 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.”.

(d) 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”.

(2) CEREMONIAL AMENDMENT.—Such Act is amended, in the table of contents in section 202, by striking the item relating to section 202 and inserting the following new item: “Sec. 257. Defense established program to stimulate competitive research.”

(3) CONFORMING AMENDMENT.—Section 307 of the Department of Defense Authorization Act of 1996 is amended by striking “(c) Experimental” and inserting “(c) Established”.

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 concurrent resolution on the budget for fiscal year 2017; as follows:

Strike all after line one and insert the following:

The Act may be cited as the “Better Care Reconciliation Act of 2017”.

TITLE I

SEC. 101. ELIMINATION OF LIMITATION ON RECAPTURE OF PAYMENTS OF PREMIUM TAX CREDITS.

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

“(iii) NONAPPLICABILITY OF LIMITATION.—This subparagraph shall not apply to taxable years ending after December 31, 2017.”.

SEC. 102. RESTRICTIONS FOR THE PREMIUM TAX CREDIT.

(a) ELIGIBILITY FOR CREDIT.—

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

(A) by striking “equals or exceeds 100 percent but does not exceed 400 percent” in subparagraph (A) and inserting “does not exceed 300 percent”, and

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

(2) TREATMENT OF CERTAIN ALIENS.—

(A) IN GENERAL.—Paragraph (2) of section 36B(c) of the Internal Revenue Code of 1986 is amended by striking “an alien lawfully present in the United States” and inserting “a qualified alien (within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996)”.

(B) AMENDMENTS TO PATIENT PROTECTION AND AFFORDABLE CARE ACT.—

(i) Section 111(a)(1) of the Patient Protection and Affordable Care Act is amended by striking “or an alien lawfully present in the United States” and inserting “or a qualified alien (within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996)”.

(ii) Section 111(c)(2)(B) of such Act is amended by striking “an alien lawfully present in the United States” each place it appears in clauses (i)(I) and (i)(II) and inserting “a qualified alien (within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996)”.

(iii) Section 1412(d) of such Act is amended—

(I) by striking “not lawfully present in the United States” and inserting “not citizens or nationals of the United States or qualified aliens (within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996)”;

(II) by striking “INDIVIDUALS NOT LAWFULLY PRESENT” in the heading and inserting “CERTAIN ALIENS”;

(b) MODIFICATION OF LIMITATION ON PREMIUM ASSISTANCE AMOUNT.—

(1) USE OF BENCHMARK PLAN.—

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

(i) by striking “applicable second lowest cost silver plan” each place it appears in paragraph (2)(B)(i) and (3)(C) and inserting “applicable median cost benchmark plan”;

(ii) by striking “such silver plan” in paragraph (2)(C) and inserting “such benchmark plan”;

and

(iii) in paragraph (3)(B)

(I) by redesignating clauses (i) and (ii) as clauses (ii) and (iii) and (iv) and (v) respectively, and by striking all that precedes clause (iii) (as so redesignated) and inserting the following:

“(B) APPLICABLE MEDIAN COST BENCHMARK PLAN.—The applicable median cost benchmark plan with respect to any applicable taxpayer is the qualified health plan offered...
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,

“(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, a premium nearest (but not in excess of) such median premium),”.

and

“(II) by striking “clause (ii)(I)” in the flush text of subsection (f) and inserting “clause (ii)(IV)”.

(B) WAIVER OF ACTUARIAL VALUE STANDARD FOR HERNMARK 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.”.

(2) 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 it and inserting “from the initial premium percentage and (25 percent in the case of a claim for refunds or credit relating to the health insurance credit under section 36B)”.

In the case of house- hold income (expressed as a percent of the poverty line) within the following income tiers:

<table>
<thead>
<tr>
<th>Income Tier</th>
<th>Up to Age 29</th>
<th>Age 30-39</th>
<th>Age 40-49</th>
<th>Age 50-59</th>
<th>Over Age 59</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Initial</td>
<td>% Final</td>
<td>% Initial</td>
<td>% Final</td>
<td>% Initial</td>
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<tr>
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<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>100%-133%</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
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</tr>
<tr>
<td>131%-150%</td>
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<td>2.5</td>
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<td>150%-200%</td>
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<td>4</td>
<td>4.3</td>
<td>5.9</td>
<td>8.05</td>
</tr>
<tr>
<td>200%-250%</td>
<td>4.3</td>
<td>5.2</td>
<td>5.9</td>
<td>8.05</td>
<td>8.39</td>
</tr>
<tr>
<td>250%-300%</td>
<td>5.2</td>
<td>5.9</td>
<td>8.05</td>
<td>8.39</td>
<td>10</td>
</tr>
<tr>
<td>300%-350%</td>
<td>5.9</td>
<td>8.05</td>
<td>8.39</td>
<td>10</td>
<td>10.5</td>
</tr>
</tbody>
</table>

(B) by striking “.504” in clause (ii)(III) and inserting “.04”.

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

“(iii) AGE 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).

(c) ELLIMINATION OF ELIGIBILITY EXCEPTIONS FOR EMPLOYER-SPONSORED COVERAGE.—

(1) IN GENERAL.—Section 36B(c)(2) 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).

(d) 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 a 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:

“(7) Exclusion of certain health plans.—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).”.

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

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 “(50 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 “(50 in the case of months beginning after December 31, 2015)” after “$1,000”.

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

SEC. 108. STATE STABILITY AND INNOVATION FUND.

(a) IN GENERAL.—

(1) APPROPRIATION.—There are authorized to be appropriated, out of monies in the Treasury not otherwise obligated, $15,000,000,000 for each of calendar years 2018 and 2019, and $15,000,000,000 for each of calendar years 2020 and 2021, to the Administrator of the Centers for Medicare & Medicaid Services (in this subsection and subsection (1) referred to as the ‘Administrator’), to fund arrangements with health insurance issuers to assist in the purchase of health benefits coverage by addressing coverage and access disruption and responding to urgent health care needs within States. Funds appropriated under this paragraph shall remain available until expended.

(2) PARTICIPATION REQUIREMENTS.—

(2)(A) GUIDANCE.—Not later than 30 days after the date of enactment of this subsection, the Administrator shall issue guidance to health insurance issuers regarding how to submit a notice of intent to participate in the program established under this subsection.

(2)(B) NOTICE OF INTENT TO PARTICIPATE.—To be eligible for funding under this subsection, a health insurance issuer shall submit to the Administrator a notice of intent to participate at such time (but, in the case of funding for calendar year 2018, not later than 35 days after the date of enactment of this subsection and, in the case of funding for calendar year 2019, 2020, 2021, 2022, 2023, 2024, 2025, or 2026, not later than March 31 of the previous year) and in such form and manner as specified by the Administrator and containing—
“(i) A certification that the health insurance issuer 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 funds under this subsection. The Administrator shall provide to States receiving payments under this subsection and shall be used only for the activities specified in paragraph (1)(A)(ii) of subparagraph (A) of this subsection.

(4) ADDITIONAL SUPPORT FOR STABILIZING PREMIUMS AND PROMOTING CHOICE IN PLANS OFFERED IN THE INDIVIDUAL MARKET.—

(A) In addition to the amounts appropriated under paragraph (1), there is appropriated, out of any money in the Treasury, not otherwise obligated, $10,000,000,000 for each of calendar years 2020 through 2026, for the purpose of funding arrangements with health insurance issuers to support the qualified health plans in States in which such issuers also offer coverage in accordance with section 212(a) of the Better Care Reconciliation Act.

(B) A certification that none of the funds provided under this subsection shall be used for the State for an expenditure that is attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure to finance the non-Federal share of expenditures required under any provision of law, including under the State plans established under title XIX or under a waiver of such plans.

(5) PAYMENTS.—

(A) ANNUAL PAYMENT OF ALLOTMENTS.—Subject to subparagraph (B), the Administrator shall pay to each State an amount equal to the Federal percentage of the State's expenditures for the non-Federal share of the costs of health care services furnished to individuals who have or are projected to be uninsured, 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, 20 percent;

(iii) in the case of calendar year 2021, 22 percent;

(iv) in the case of calendar year 2022, 23 percent;

(v) in the case of calendar year 2023, 24 percent;

(vi) in the case of calendar year 2024, 25 percent;

(vii) in the case of calendar year 2025, 26 percent; and

(viii) in the case of calendar year 2026, 27 percent.

(B) STATE EXPENDITURES REQUIRED BEGINNING 2022.—For purposes of paragraph (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 require to carry out this subsection for each year on the basis of advance estimates of expenditures submitted by the 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 and the applicable percentage specified in clause (i) of section 15004(a)(1) of the Social Security Act.

(ii) ANNUAL REDISTRIBUTION OF PREVIOUS YEAR’S UNUSED FUNDS.—

(A) IN GENERAL.—In carrying out clause (i) with respect to a year (beginning with 2021), the Administrator shall, not later than March 31 of such year—

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

(bb) if the Administrator determines that any funds so remain from the previous year, distribute 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.

(B) APPlicable STATE PERCENTAGE.—The State percentage specified for a year in paragraph (5)(B)(ii) shall apply to funds redistributing any payments under this subsection.

(7) AVAILABILITY OF ALLOCATED STATE FUNDS.—

(A) ANNUAL PAYMENT OF ALLOTMENTS.—Subject to subparagraph (B), the Administrator shall pay to each State an amount equal to the Federal percentage of the State's expenditures for the non-Federal share of the costs of health care services furnished to individuals who have or are projected to be uninsured, 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, 20 percent;

(iii) in the case of calendar year 2021, 22 percent;

(iv) in the case of calendar year 2022, 23 percent;

(v) in the case of calendar year 2023, 24 percent;

(vi) in the case of calendar year 2024, 25 percent;

(vii) in the case of calendar year 2025, 26 percent; and

(viii) in the case of calendar year 2026, 27 percent.

(B) STATE EXPENDITURES REQUIRED BEGINNING 2022.—For purposes of paragraph (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.

(C) APPROPRIATION; TOTAL ALLOTMENT.—For the purpose of providing allotments to States under this subsection, there is appropriated, out of any money in the Treasury not otherwise appropriated—

(i) for calendar year 2019, $8,000,000,000;

(ii) for calendar year 2020, $9,000,000,000;

(iii) for calendar year 2021, $9,000,000,000;

(iv) for calendar year 2022, $33,200,000,000;

(v) for calendar year 2023, $33,300,000,000;

(vi) for calendar year 2024, $33,200,000,000;

(vii) for calendar year 2025, $33,300,000,000; and

(viii) for calendar year 2026, $33,300,000,000.

(D) ALLOCATIONS TO STATES.—

(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 amount of payments met for the year and that reserves an amount that is at least 1 percent of the amount appropriated under subparagraph (A) for each year for allotments 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 and the applicable percentage specified in clause (i) of section 15004(a)(1) of the Social Security Act.
State and such other investigation as the Administrator shall find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for the preceding year.

(11) MISUSE OF FUNDS.—If the Administrator determines that a State is not using funds paid to the State under this subsection in a manner consistent with the directions provided by the State in its application approved under paragraph (1), the Administrator may withhold payments, reduce payments, or offset payments by amounts appropriated for each such year under paragraph (4)(A) for States for the purposes described in paragraph (1)(A)(v) and in accordance with guidance issued by the Administrator not later than 30 days after the date of enactment of this subsection that specifies the parameters for the use of funds for such purposes.

(12) REQUIRED USE.—

(A) PREMIUM STABILIZATION AND INCENTIVES FOR INDIVIDUAL MARKET PARTICIPANTS.—In determining allotments for States under this subsection for each of calendar years 2019, 2020, and 2021, the Administrator shall ensure that at least $5,000,000,000 of the amounts appropriated for each such year under paragraph (4)(A) are used by States for the purposes described in paragraph (1)(A)(iv) and in accordance with guidance issued by the Administrator not later than September 1, 2019, that specifies the parameters for the use of funds for such purposes.

(B) ASSISTANCE WITH OUT-OF-POCKET COSTS.—In determining allotments for States under this subsection for each of calendar years 2020 through 2026, the Administrator shall ensure that at least $15,000,000,000 of the amounts appropriated for each of calendar years 2020 and 2021 under paragraph (4)(A) are used by States for the purposes described in paragraph (1)(A)(iv) and in accordance with guidance issued by the Administrator not later than 30 days after the date of enactment of this subsection that specifies the parameters for the use of funds for such purposes.

(7) EXEMPTIONS.—Paragraphs (2), (3), (5), (6), (8), (10), and (11) of subsection (c) do not apply to payments under this subsection.

(8) FUNDING.—There is appropriated to the Treasury not otherwise appropriated, $500,000,000.

SEC. 106. REPEAL OF THE TAX ON EMPLOYER HEATING, COOLING, AND ELECTRICITY PREMIUMS AND HEALTH PLAN BENEFITS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by striking “section 204”.

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

SEC. 107. BETTER CARE RECONCILIATION IMPLEMENTATION FUND.

(a) IN GENERAL.—There is hereby established a Better Care Reconciliation Implementation Fund (referred to in this section as the “Fund”) within the Department of Health and Human Services to provide for Federal administrative expenses in carrying out this Act.

(b) FUNDING.—There is appropriated to the Fund, out of any funds in the Treasury not otherwise appropriated, $500,000,000.

SEC. 108. REPEAL OF THE 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.—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 payments with respect to taxable years beginning after December 31, 2020.

(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred in taxable years beginning after December 31, 2020.

SEC. 109. 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, 2020.

SEC. 110. 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 (l),

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to plan years beginning after December 31, 2020.

SEC. 111. REPEAL OF TAX ON PRESCRIPTION MEDICATIONS.

Subsection (j) of section 9008 of the Patient Protection and Affordable Care Act is amended by striking “and” and inserting “; and” at the end of paragraph (1) and all that follows through “2017.”

SEC. 112. REPEAL OF MEDICAL DEVICE EXCISE TAX.

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

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

SEC. 113. REPEAL OF HEALTH INSURANCE TAX.

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

SEC. 114. REPEAL OF ELIMINATION OF DEDUCTION FOR EXCESSIVE PREMIUMS AND COST SHARING ELIGIBILITY AND ELIGIBLE MEDICARE PART D SUBSIDY.

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

“this section shall not be taken into account for purposes of determining whether any deduction is allowable with respect to such credit taken into account in determining such payment.”

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

SEC. 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 “7.5 percent”.

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

SEC. 117. REPEAL OF TANING TAX.

(a) IN GENERAL.—The Internal Revenue Code of 1986 is amended by striking chapter 42.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to plan years beginning after September 30, 2016.

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

(a) PURCHASE OF HIGH DEDUCTIBLE HEALTH PLANS.

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

(A) by striking “and” and inserting “or to carry on any business of providing personal, family, or household services;”;

(B) by striking subsection (i).

(2) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after September 30, 2016.

(b) CONSUMER FREEDOM PLANS.—

(2) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after September 30, 2017.

(c) By striking “or” at the end of paragraph (1) and all that follows through “coordinated care organization.”

(d) By striking subsection (d).

SEC. 119. REPEAL OF TANNING TAX.

(a) IN GENERAL.—Section 333 of the Internal Revenue Code of 1986 is amended—

(1) by striking “tanning” and inserting “tanning service”;

(2) by striking “or” at the end of paragraph (1) and all that follows through “coordinated care organization.”

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after September 30, 2017.

(c) By striking “or” at the end of paragraph (1) and all that follows through “coordinated care organization.”

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after September 30, 2017.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after September 30, 2017.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after September 30, 2017.

SEC. 120. ELIMINATION OF ESTATE AND GIFT TAX.

(a) IN GENERAL.—Section 2036 of the Internal Revenue Code of 1986 is amended by striking “20%” and inserting “10%”.

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

SEC. 121. ELIMINATION OF ESTATE AND GIFT TAX.

(a) IN GENERAL.—Section 2036 of the Internal Revenue Code of 1986 is amended by striking “20%” and inserting “10%”.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to deaths occurring after December 31, 2017.
"(vi) any plan which—

"(I) is offered by a health insurance issuer which meets the conditions described in section 212(b) of the Better Care Reconciliation Act of 2017, for the plan year, and

"(II) would not be permitted to be offered in the market but for such section," and

(b) by inserting "or (vi)" after "clause (v)" in the entity paragraphs.

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

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 "$2,250" and inserting "the amount in effect under subsection (c)(2)(A)(i)(II)".

(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)(I)".

(c) COST-OF-LIVING ADJUSTMENT.—Section 223(b)(2)(B) of such Code is amended—

(1) by striking "subsection (b)(2) and both places it appears and inserting "subsection (c)"; and

(2) in subparagraph (B), by striking "determined by" and all that follows through "calendar year 2003."

(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 ADDITIONAL 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—

"(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 either 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 such limitation (after 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 rules between the spouses.

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

(iii) by inserting at the end the following new subparagraphe:

“(E) 90 percent for calendar quarters in 2020;”

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

“(G) 80 percent for calendar quarters in 2022;” and

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

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

“(i) the terms ‘expansion State’ means—

(1) in the case of a State that provides medical assistance to newly eligible individuals (as defined in section 1902(nn)(1)) to individuals who either are eligible for medical assistance under this title (or provides eligibility for individuals described in such subclause under a waiver of the State plan approved under section 1115) for each of fiscal years 2021 through 2023 and fiscal years thereafter; and

(2) in the case of a State that provides medical assistance to newly eligible individuals (as defined in section 1902(nn)(1)) to individuals who are eligible for medical assistance under this title (or provides eligibility for individuals described in such subclause under a waiver of the State plan approved under section 1115), for each fiscal year thereafter.”

SEC. 126. RESTORING FAIRNESS IN DSH ALLOTMENTS.

Section 1923(f)(7) of the Social Security Act (42 U.S.C. 1396a(aa)(7)) is amended by striking “and” and inserting “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

(i) in subparagraph (B)(ii)—

(1) in clause (I), by inserting “and, for periods after December 31, 2019, and before January 1, 2024, who are expansion enrollees (as defined in section 1902(nn)(1))” after “for which payment is permitted under subclause (VIII),” and

(2) in clause (II), by inserting “for which payment is permitted under subclause (VIII)” after “for which payment is permitted under subclause (VII).”

(ii) by striking “or after the third month before the month in which the recipient makes application for assistance” and inserting “in or after the month in which the recipient makes application for assistance, or, in the case of a recipient who is 65 years of age or older or who is eligible for medical assistance with respect to individuals of being blind or disabled at the time application is made, in or after the third month before the month in which the recipient makes application for assistance”;

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to medical assistance with respect to individuals whose eligibility for such assistance is based on an application for such assistance made (or deemed to be made) on or after October 1, 2021.

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:

“SEC. 1923A. (a) IN GENERAL.—Subject to the limitations of this section, for each year during the period beginning with fiscal year 2022 and ending with fiscal year 2026, 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 medical assistance to newly eligible individuals under clause (I) of section 1902(a)(10)(A) for medical assistance under this title (or a waiver of that section applicable to such assistance) or 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 otherwise provided under the State plan under this title (or a waiver of such plan) to health care providers that provide health care services to individuals enrolled under this title (or deemed to be ‘eligible providers’) so long as the payment adjustment to such an eligible provider does not exceed the payment adjustment for such 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 applicable with respect to expenditures attributable to a payment adjustment under subsection (a) for which payment is permitted under subsection (a) shall be—

(1) 100 percent for calendar quarters in fiscal years 2018, 2019, 2020, and 2021; and

(2) 95 percent for calendar quarters in fiscal year 2022.

(c) ANNUAL ALLOTMENT LIMITATION. —Payment under section 1903(a) shall not be made to a State with respect to any payment adjust-ment 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—

(1) the population of the State with income below 138 percent of the poverty line in 2015 (as determined based on the table entitled ‘‘Federal Insurance Coverage by Ratio of Income to Poverty Level in the Past 12 Months by Age’’ for the universe of the civilian noninstitutionalized population for which poverty status is based on the 2015 American Community Survey 1-Year Estimates, as published by the Census Bureau), to

(2) the sum of the populations under paragraph (1) for all non-expansion States.

(d) DISQUALIFICATION IN CASE OF STATE CANCELLATION.—The payment adjustment for a fiscal year and provides eligi-bility for medical assistance described in


equal to the higher of the percentage otherwise determined for the State and year under subsection (b) (without regard to this subsection) and:

(i) the percentage otherwise determined for the State described in section 1902(nn)(1) shall be equal to the higher of—

(I) the population of the State with income below 138 percent of the poverty line in 2015 (as determined based on the table entitled ‘‘Federal Insurance Coverage by Ratio of Income to Poverty Level in the Past 12 Months by Age’’ for the universe of the civilian noninstitutionalized population for which poverty status is based on the 2015 American Community Survey 1-Year Estimates, as published by the Census Bureau), to

(2) the sum of the populations under paragraph (1) for all non-expansion States.

(e) ANNUAL ALLOTMENT LIMITATION. —Payment under section 1903(a) shall not be made to a State with respect to any payment adjust-ment 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—

(1) the population of the State with income below 138 percent of the poverty line in 2015 (as determined based on the table entitled ‘‘Federal Insurance Coverage by Ratio of Income to Poverty Level in the Past 12 Months by Age’’ for the universe of the civilian noninstitutionalized population for which poverty status is based on the 2015 American Community Survey 1-Year Estimates, as published by the Census Bureau), to

(2) the sum of the populations under paragraph (1) for all non-expansion States.

(f) DISQUALIFICATION IN CASE OF STATE CANCELLATION.—The payment adjustment for a fiscal year and provides eligi-bility for medical assistance described in


equal to the higher of—

(I) the population of the State with income below 138 percent of the poverty line in 2015 (as determined based on the table entitled ‘‘Federal Insurance Coverage by Ratio of Income to Poverty Level in the Past 12 Months by Age’’ for the universe of the civilian noninstitutionalized population for which poverty status is based on the 2015 American Community Survey 1-Year Estimates, as published by the Census Bureau), to

(2) the sum of the populations under paragraph (1) for all non-expansion States.

(g) ANNUAL ALLOTMENT LIMITATION. —Payment under section 1903(a) shall not be made to a State with respect to any payment adjust-ment 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—

(1) the population of the State with income below 138 percent of the poverty line in 2015 (as determined based on the table entitled ‘‘Federal Insurance Coverage by Ratio of Income to Poverty Level in the Past 12 Months by Age’’ for the universe of the civilian noninstitutionalized population for which poverty status is based on the 2015 American Community Survey 1-Year Estimates, as published by the Census Bureau), to

(2) the sum of the populations under paragraph (1) for all non-expansion States.
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. 119. OPTIONAL WORK REQUIREMENT FOR NONDISABLED, NONELDERLY, NONPREGNANT INDIVIDUALS.**

(a) In General.—Section 1902(o)(14) of the Social Security Act (42 U.S.C. 1396a(o)(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 an individual 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 matching percentage otherwise applicable under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) with respect to the State during such quarter that are attributable to meeting the requirement of section 1902(e)(14) (relating to determinations of eligibility using modified adjusted gross income) of such Act shall be increased 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 made on a 6-month or shorter basis) (as added by subsection (a)) to increase the frequency of eligibility redeterminations.

**SEC. 130. OPTIONAL WORK REQUIREMENT FOR NONDISABLED, NONELDERLY, NONPREGNANT INDIVIDUALS.**

(a) In General.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as previously amended, is further amended by adding at the end the following:

“(oo) OPTIONAL WORK REQUIREMENT FOR NONDISABLED, NONELDERLY, NONPREGNANT INDIVIDUALS.—

(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 matching percentage otherwise applicable under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) with respect to the State during such quarter that are attributable to meeting the requirement of section 1902(e)(14) (relating to determinations of eligibility using modified adjusted gross income) of such Act shall be increased 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 made on a 6-month or shorter basis) (as added by subsection (a)) to increase the frequency of eligibility redeterminations.

**SEC. 131. PROVIDER TAXES.**

Section 1905(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:

“(k) FREQUENCY OF ELIGIBILITY REDETERMINATIONS.—Beginning on October 1, 2017, and notwithstanding subparagraph (h), in the case of an individual whose eligibility for medical assistance under the State plan under 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).”

**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) in subsection (a), in the matter before paragraph (1), by inserting “and notwithstanding subparagraph (D), not less than 4)” after “weight by the Secretary”;

(B) in subsection (d)(1), by striking “to which” and inserting “to which, subject to section 1903(a)(4),”;

(2) in subsection (d)(3) (as so amended), by striking “such amount” and inserting “such amount,”;

(b) InCREASED MATCHING PERCENTAGE.—For each fiscal year, the term ‘work requirement’ 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 1906(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 and fiscal year.

(c) Parameters.—In selecting a 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 paragraph (D), not less than 4 consecutive fiscal quarters that begins with a fiscal quarter earlier than the first quarter of fiscal year 2014 or ends with a fiscal quarter during fiscal year 2017;

(ii) shall not select any period of 8 or, in the case of a State selecting a period under paragraph (D), not less than 4 consecutive fiscal quarters that begins with a fiscal quarter earlier than the first quarter of fiscal year 2014 or ends with a fiscal quarter during fiscal year 2017.

(d) BASE PERIOD FOR LATE-EXPANDING STATES.—In the case of a State that did not provide for medical assistance for the 1963A enrolled category described in subsection (e)(2)(D) as of the first day of the fourth fiscal quarter of fiscal year 2015 but which provided 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.

(i) 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.

(ii) APPLICATION OF OTHER REQUIREMENTS.—The adjustments to amounts for per capita base periods required under subsections (b)(5) and (d)(4) 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 ‘divided by 2’ in such subsection.

(E) 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 cap to diminish the eligibility 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.—Subject to subsection (g), the following shall apply:

(1) In general.—In this section, the term ‘adjusted total medical assistance expenditures’ means, for a State—

(A) for its per capita base period (as defined in subsection (a)(5)), the product of—

(i) the amount of the medical assistance expenditures (as defined in paragraph (3)) for the State and period, reduced by the amount of any excluded expenditures (as defined in paragraph (3) and payments described in subsection (d)(4)(A)(ii)) for the State and period otherwise included 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, of the medical assistance expenditures (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 otherwise included in such medical assistance expenditures and includes non-DSH supplemental payments (as defined in subsection (d)(4)(A)(ii)) and payments described in subsection (d)(4)(A)(iii) but shall not be construed as including any expenditures attributable to the program under section 1928 relating to State pediatric vaccine distribution programs. In applying subparagraph (B), non-DSH supplemental payments (as defined in subsection (d)(4)(A)(ii)) and payments described in subsection (d)(4)(A)(iii) shall be treated as fully attributable to 1903A enrollees.

(2) Medical Assistance Expenditures.—In this section, the term ‘medical assistance expenditures’ means, for a State and fiscal year, the total amount of expenditures for the period described in subparagraph (A) for each enrollee category, State, and fiscal year under the State plan under this title (or under a waiver of such plan) for a fiscal year under the State plan under this title (or under a waiver of such plan) for a fiscal year beginning with fiscal year 2020, the target per capita medical assistance expenditures for fiscal year 2019 for 1903A enrollees in the State for which payment is made pursuant to subsection (a)(3), and payments described in subsection (d)(4)(A)(ii) made pursuant to section 1903(a)(1), adjusted, in the case of a per capita base period, under paragraph (5).

(3) Aggregate Limitation on Exclusions and Additions Payments.—The aggregate amount of expenditures excluded under this paragraph and additional payments made under section 1903B(c)(3)(E) for the period described in subparagraph (A) shall not exceed the amount by which any overpayment described in subparagraph (A)(i) for a fiscal year or portion of a fiscal year under the State plan under this title (or under a waiver of such plan) for a fiscal year involved during which no such declaration was in effect.

(4) Target Total Medical Assistance Expenditures.—(I) In general.—In this section, the term ‘target total medical assistance expenditures’ means, for a State for a fiscal year and subject to paragraph (4), the sum of the products, for each of the 1903A enrollee categories (as defined in subsection (o)(2)), of—

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

(B) the number of 1903A enrollees for such enrollee category, State, and fiscal year, as determined under subsection (e)(4).

(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—

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

(II) 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; increased by—

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

(3) Applicable Annual Inflation Factor.—In paragraph (2), the term ‘applicable annual inflation factor’ means, for fiscal years before 2025—

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

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

(B) for fiscal years after 2024, for all 1903A enrollee categories, 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.

(4) Decrease in Target Expenditures for Required Expenditures by Certain Political Subdivisions.—(A) General. —In the case of a State that had a DSH allotment under section 1923(f) for fiscal year 2016 that was more than 6 times the national average of such allotments for all the States for such fiscal year and that requires political subdivisions within the State to contribute funds towards medical assistance or other expenditures under the State plan under this title (or under a waiver of such plan) for a fiscal year (beginning with fiscal year 2020), the target total medical assistance expenditures for such State and fiscal year shall be decreased by the amount that political subdivisions in the State are required to contribute under the plan (or waiver) without reimbursement from the State for such fiscal year, other than contributions described in subparagraph (B).

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

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

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

(II) imposes a local income tax upon its residents.
"(ii) Contributions required by a State from a political subdivision for 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, fiscal year, as determined under paragraph (2), shall be adjusted (subject to subparagraph (C)(i)) in accordance with this paragraph.

(B) LIMITATION ON LEVEL OF PER CAPITA SPENDING FOR 1903A ENROLLEE CATEGORIES.—Subject to subparagraph (C), with respect to a State, fiscal year, and 1903A enrollee category, if the State’s per capita categorical medical assistance expenditures (as defined in subparagraph (D)) for the State and category in the preceding fiscal year—

(i) exceed the mean per capita categorical medical assistance expenditures for the category for all States for such preceding year by not less than 25 percent, the State’s target per capita medical assistance expenditures for the fiscal year involved shall be reduced by a percentage that shall be determined by the Secretary but which may not be less than 0.5 percent or greater than 3 percent; or

(ii) are less than the mean per capita categorical medical assistance expenditures for the category for all States for such preceding year by not less than 25 percent, the State’s target per capita medical assistance expenditures for the fiscal year involved shall be increased by a percentage that shall be determined by the Secretary but which may not be less than 0.5 percent or greater than 3 percent.

(C) APPLICATION.—

(i) BUDGET NEUTRALITY REQUIREMENT.—In determining the appropriate percentages by which to adjust States’ target per capita medical assistance expenditures for a category and fiscal year under this paragraph, the Secretary shall make such adjustments in a manner that does not result in a net increase in Medicaid and CHIP expenditures under paragraphs (A) through (D) for such fiscal year, and if the Secretary cannot adjust such expenditures in such a manner there shall be no adjustment under this paragraph for such fiscal year.

(ii) ASSUMPTION REGARDING STATE EXPENDITURES.—For purposes of clause (i), in the case of a State that has its target per capita medical assistance expenditures for a 1903A enrollee category and fiscal year increased under this paragraph, the Secretary shall assume that the categorical medical assistance expenditures for such State (as defined in subparagraph (D)(ii)) for such State, category, and fiscal year will equal such increased target medical assistance expenditures.

(D) ADJUSTMENT TO LOW-DENSITY STATES.—This paragraph shall not apply to any State that has a population density of less than 15 individuals per square mile, based on most recent data available from the Bureau of the Census.

(E) DISREGARD OF ADJUSTMENT.—Any adjustment under this paragraph to target medical assistance expenditures for a 1903A enrollee category, and fiscal year shall be disregarded when determining the target medical assistance expenditures for such State and fiscal year for a succeeding year under paragraph (2).

(V) APPLICATION FOR FISCAL YEARS 2020 AND 2021.—In fiscal years 2020 and 2021, the Secretary shall make such adjustments by applying the percentage determined under this paragraph to the amount of such payments for the State and category for the preceding fiscal year, as calculated under paragraph (2).

(VI) PER CAPITA MEDICAL ASSISTANCE EXPENDITURES.—(i) IN GENERAL.—In this paragraph, the term per capita categorical medical assistance expenditures means, with respect to a State, 1903A enrollee category, and fiscal year, an amount equal to—

(I) the categorical medical assistance expenditures (as defined in subsection (b)(1) for the State, category, and year; divided by

(II) the number of 1903A enrollees for the State, category, and year.

(ii) CATEGORICAL MEDICAL ASSISTANCE EXPENDITURES.—The term ‘categorical medical assistance expenditures’ means, with respect to a State, 1903A enrollee category, and fiscal year, the medical assistance expenditures (as defined in paragraph (2)) for the State and fiscal year that are attributable to 1903A enrollees in the category, excluding any excluded expenditures (as defined in paragraph (3)) for the State and fiscal year that are attributable to 1903A enrollees in the category.

(VII) CALCULATION OF FY19 PROVISIONAL TARGET AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—Subject to subsection (g), the following shall apply:

(1) CALCULATION OF BASE AMOUNTS FOR PER CAPITA EXPENDITURES.—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 State’s per capita base period;

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

(C) the average per capita medical assistance expenditures for the State for the State’s per capita base period equal to—

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

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

(2) FISCAL YEAR 2019 AVERAGE PER CAPITA AMOUNT BASED ON INFLATING THE PER CAPITA BASE PERIOD AMOUNT TO FISCAL YEAR 2019 BY CPI-MEDICAL.—The Secretary shall calculate a fiscal year 2019 average per capita amount for each 1903A enrollee category equal to—

(A) the average per capita medical assistance expenditures for the State for the State’s per capita base period calculated under paragraph (1), 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 last three months of the State’s per capita base period to September of fiscal year 2019;

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

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

(B) the number of 1903A enrollees for the State for fiscal year 2019 (as determined under subsection (e)(4)).

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

(A)(i) For each 1903A enrollee category, the average per capita medical assistance expenditures (as defined in subsection (b)(1)) for the State for fiscal year 2019 for individuals in the enrollee category, excluding any excluded expenditures those expenditures attributable to expenditures described in clause (iii) or non-DSH supplemental expenditures (as defined in clause (ii)).

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

(5) PROVISIONAL FY19 PER CAPITA TARGET AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—For each 1903A enrollee category, the Secretary shall calculate for each State a provisional per capita target amount for fiscal year 2019 for individuals in the enrollee category for the purposes of funding a delivery system reform pool, uncompensated care pool, a designated State health program, or any other similar expenditure (as defined by the Secretary).

(B) For each 1903A enrollee category, the number of 1903A enrollees for the State in fiscal year 2019 in the enrollee category, as determined under subsection (e)(4).

(C) For the State’s per capita base period, the State’s non-DSH supplemental and pool payment percentage is equal to the ratio (expressed as a percentage) of—

(i) the total amount of non-DSH supplemental expenditures and payments described in subparagraph (A)(ii) as a percentage of the total amount of DSH supplemental expenditures and payments described in subparagraph (C) (as calculated under subparagraph (E)) and payments described in subparagraph (A)(ii) (and adjusted under subparagraph (E)) for the State for the period, to

(ii) the number calculated described in subsection (b)(1)(A) for the State for the State’s per capita base period.

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

(i) the amount calculated under subparagraph (A) for the State, increased by the non-DSH supplemental and pool payment percentage calculated under subparagraph (C); divided by

(ii) the number calculated under subparagraph (B) for the State for the enrollee category.

(E) For purposes of subparagraph (C)(i), in calculating the total amount of non-DSH supplemental expenditures and payments described in subparagraph (A)(ii) for the State for the per capita base period, the total amount of such expenditures and the total amount of such payments for the State and base period shall each be divided by 2.
(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 (9)(D) or (E)) who—

(A) is an individual who is provided, under this title in the manner described in section 2101(a)(2), child health assistance under title XI;

(B) receives any medical assistance under this title only on the basis of a waiver that provides only comparable benefits.

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

(A) ELDERLY.—A category of 1903A enrollees who are 65 years of age or older;

(B) BLIND AND DISABLED.—A category of 1903A enrollees who is blind or disabled.

(3) EXPANSION ENROLLEES.—A category of 1903A enrollees (not described in a previous subparagraph) who—

(A) are enrolled under a State plan to provide medical assistance for the purpose of ensuring (through primary care) that the enrollee’s health status is maintained in order to avoid hospitalization or other inpatient care;

(B) are enrolled under a State plan to provide medical assistance for the purpose of ensuring (through primary care) that the enrollee’s health status is maintained in order to avoid hospitalization or other inpatient care.

(4) DETERMINATION OF NUMBER OF 1903A ENROLLEES.—The number of 1903A enrollees for a State and fiscal year or the State’s per capita base period, and, if applicable, for a 1903A enrollee category, is the average monthly number of Medicaid enrollees for such period (and, if applicable, in such category) that are reported through the CMS–64 report under (and subject to audit under) subsection (b).

(1) APPLICATION IN CASE OF RESEARCH AND DEMONSTRATION PROJECTS AND OTHER WAIVERS.—In the case of a State with a waiver of the State plan requirements under section 1115, section 1902(a)(10)(A)(i)(XXIII) or another provision of this title, this section shall apply to medical assistance expenditures and medical assistance enrollees in the same manner as if such expenditures and enrollees had been made under a State plan under this title and the limitations on expenditures under this section shall supersede any other payment limitations or provisions (including limitations based on a per capita limitation) otherwise applicable under such a waiver.

(2) TREATMENT OF STATES EXPANDING COVERAGE AFTER JULY 1, 2016.—In the case of a State that did not provide for medical assistance for the categories described in subsection (e)(2)(D) as of July 1, 2016, but which subsequently provides for medical assistance for such categories, such provision shall be treated as if the State had provided for medical assistance for such categories on the date of the enactment of this section.

(3) IN CASE OF STATE FAILURE TO REPORT REQUIRED DATA.—In the case of any State that fails to report required data under this section, the Secretary shall modify the CMS–64 report form to require that States submit data with respect to medical assistance expenditures for qualified inpatient psychiatric hospital services (as defined in section 1902(h)(3)).

(4) AUDITING OF CMS–64 DATA.—The Inspector General of the Health and Human Services 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, for which audit may be conducted on a representative sample (as determined by the Secretary).
increased by 10 percentage points to 100 percent;

''(B) the Federal matching percentage applied under section 1903(a)(3)(B) shall be increased by 25 percentage points to 100 percent; and

''(C) the Federal matching percentage applied under section 1903(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 demonstration project on a competitive basis except for:

''(i) demonstration projects with respect to enrollees described in section 1922(a)(7) for which the Secretary determines that the enrollee category described in subparagraph (A) is not a program to determine whether such enrollee category described in subparagraph (A) is not a program.

''(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 for purposes of making 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:

''(A) in subsection (a), by striking the first paragraph and inserting the following:

''(1) ANNUAL ALLOTMENT.—Subject to clause (ii), for each year of the demonstration project, the Secretary shall allot an amount to each State that is an eligible State for the year.

''(ii) LIMITATION ON FEDERAL SPENDING.—The aggregate amount that may be allotted to eligible States under clause (i) for all years of the demonstration project shall not exceed $8,000,000,000, and in no case may the aggregate amount of payments made by the Secretary to eligible States for payment adjustments under this subsection exceed such amount.

''(B) PAYMENTS TO ELIGIBLE STATES AND LIMITATIONS.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), for each year of the demonstration project, notwithstanding section 1905(b), the Federal medical assistance percentage applicable with respect to expenditures by an eligible State that are attributable to HCBS payment adjustments made by the Secretary for the year under subparagraph (A) is equal to (and shall in no case exceed) 100 percent.

''(ii) LIMITATION ON HCBS PAYMENT ADJUSTMENTS FOR INDIVIDUAL PROVIDERS.—Payment under this section with respect to expenditures by an eligible State for expenditures for a year that are attributable to an HCBS payment adjustment that is paid to a provider and that percentage which shall be established by the Secretary of the payment otherwise made to the provider.

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

''(G) An information technology systems plan demonstrating that the State has the capability to support the technological adoptions of the program to comply with reporting requirements under this section.

''(H) A statement of the goals 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.

''(I) Such other information as the Secretary may require.

''(4) FEDERAL 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.

(4) REDUCTION IN BLOCK GRANT AMOUNT.—Beginning in 2019 and thereafter for the State and succeeding fiscal year under clause (i) shall be treated as an overpayment under this title.

(5) 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)) for the year or portion of a year of the amount of such uncompensated targeted health assistance expenditures, except that the amount of such payment shall not exceed the amount (if any) by which—

(II) the number of 1903A enrollees in such categories in areas affected by a public health emergency are met.

(3) BUREAUCRATIC REDUCTION REQUIREMENT.—For purposes of determining the State Medicaid Flexibility Program block grant amount for any fiscal year in which the Secretary determines that the health care needs of program enrollees for the purpose of ensuring that the health care needs of program enrollees in areas affected by a public health emergency are met.

(4) DETERMINATION AND PUBLICATION OF BLOCK GRANT AMOUNT.—Beginning in 2019 and thereafter for the State and succeeding fiscal year under clause (i) shall be treated as an overpayment under this title.

(3) BUREAUCRATIC REDUCTION REQUIREMENT.—For purposes of determining the State Medicaid Flexibility Program block grant amount for any fiscal year in which the Secretary determines that the health care needs of program enrollees for the purpose of ensuring that the health care needs of program enrollees in areas affected by a public health emergency are met.

(4) DETERMINATION AND PUBLICATION OF BLOCK GRANT AMOUNT.—Beginning in 2019 and
each year thereafter, the Secretary shall de-
termine for each State, regardless of whether the
State is conducting a Medicaid Flexi-
bility Program or has submitted an applica-
tion to the Secretary for conducting a Medicaid Flexibility Program, the amount of the block grant for the State under para-
graph (2) which would apply for the upcom-
ing fiscal year if the State were to conduct such a program under this section, and publish such determinations not later than June 1 of each year.

PROGRAM REQUIREMENTS.—

\(1\) IN GENERAL.—No payment shall be
made under this section to a State con-
ducting a Medicaid Flexibility Program un-
less such program meets the requirements of
this subsection.

\(2\) TERM OF PROGRAM.—

\(A\) IN GENERAL.—A State Medicaid Flexi-
bility Program approved under subsection (b)
shall:

\(i\) be conducted for not less than 1 pro-
gram period;

\(ii\) be the option of the State, may be con-
tinued for succeeding program periods without resubmitting an application under subsection (b), provided that—

\(I\) this section provides notice to the Secre-
tary of its decision to continue the pro-
gram; and

\(II\) to significant changes are made to the pro-
gram; and

\(iii\) shall be subject to termination only
by the Secretary, which may terminate the pro-
gram by making an election under subpara-
graph (B).

\(B\) ELECTION TO TERMINATE PROGRAM.—

\(i\) IN GENERAL.—Subject to clause (ii), a
State conducting a Medicaid Flexibility Pro-
gram may elect to terminate the program ef-
fective with the first day after the end of the
program period in which the State makes the
election.

\(ii\) TRANSITION PLAN REQUIREMENT.—A
State may not elect to terminate a Medicaid Flexibility Program unless the State has in place an appropriate transition plan ap-
proved by the Secretary.

\(C\) EFFECT OF TERMINATION.—If a State elec-
to terminate a Medicaid Flexibility Program,
the per capita cap limitations under section 1903A shall apply effective with the day described in clause (i), and such limitations shall be applied as if the State had never conducted a Medicaid Flexibility Program.

\(D\) PROVISION OF TARGETED HEALTH ASSIST-
ANCE.—

\(i\) IN GENERAL.—A State conducting a
Medicaid Flexibility Program shall establish conditions for eligibility of program enrollees and such as-
sistances and services as would otherwise be provided to the enrollees under this title.

\(ii\) CONDITIONS FOR ELIGIBILITY.—

\(A\) REQUIRED SERVICES.—In the case of
program enrollees to whom the State would otherwise be required to make medical assistance available under section 1902(a)(10)(A)(i), a State conducting a Med-
icaid Flexibility Program shall provide as

\(B\) OPTIONAL BENEFITS .—A State may, at
its option, provide services in addition to the services described in subparagraph (A) as

\(C\) BENEFIT PACKAGES.—

\(i\) IN GENERAL.—In the case of a State
conducting a Medicaid Flexibility Program under this section, paragraphs (1), (10)(A), and (11) of section 1902A(a), as well as any
other provision of this title (except for this
section) that the Secretary deems appro-
priate, shall not apply.

\(C\) Waivers and State Plan Amend-
ments.—

\(i\) IN GENERAL.—In the case of a State conduct-
ing 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 to
any group of program enrollees under a Medicaid Flexibility Program shall include the aggregate actu-
arial value of the benchmark coverage described in subsection (b)(1) of section 1903A. If the State elects to terminate a Medicaid Flexibility Program, a State may mirror provisions of a waiver or State plan amendment described in clause (i) in the program to the extent that such provisions are otherwise cons-
sistent with the requirements of this section.

\(ii\) EFFECT OF TERMINATION.—In the case of a State described in clause (i) that termi-
nates its program under subsection (d)(2)(B), any limited or modified pursuant to subparagraph (A) shall cease to be so limited effective with the effective date of such termination.

\(B\) NONAPPLICATION OF PROVISIONS.—With
respect to the design and implementation of Medicaid Flexibility Programs conducted under this section, paragraphs (1), (10)(B), (17), and (23) of section 1902A(a), as well as any
other provision of this title (except for this
section) as otherwise provided by this section) that the Secretary deems appro-
riate, shall not apply.

\(C\) Definitions.—For purposes of this sec-
tion:

\(A\) APPLICABLE PROGRAM ENROLLEE CAT-
EGORY.—The term ‘applicable program en-
rollee category’ means, with respect to a State Medicaid Flexibility Program for a program period, any of the following as spec-
ified by the State for the period in its appli-
cation under subsection (b):

\(B\) EXPANSION ENROLLEES.—The 1903A en-
rollee category described in subparagraph (D) of section 1903A(a)(i)(B).

\(C\) NONELIGIBLY, NONDISABLED, NONEX-
PANION ADULTS.—The 1903A enrollee
category described in subparagraph (B) of
section 1903A(a)(i)(B).

\(D\) EXPANDED ELIGIBILITY.—The term ‘Medicaid Flexibility Program’ means a
State program for providing targeted health assistance to program enrollees funded by a block grant under this section.

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

(4) BUILDING BLOCKS 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) GRANDFATHERED WAIVER.—If the term ‘State’ means one of the 50 States or the District of Columbia.

(6) TARGETED HEALTH ASSISTANCE.—The term ‘targeted health assistance’ means assistance for health-care-related items and services described in section 1905A(e)(1) who is in the applicable program enrollee category described in section 1905A(e)(2) who is a Medicaid enrollee for the period.

(7) MEDICAL ASSISTANCE EXPENDITURES.—In this paragraph, ‘medical assistance expenditures’ means—

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

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

SEC. 134. MEDICAID AND CHIP QUALITY PERFORMANCE BONUS PAYMENTS. Section 1903(b) 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) QC PERFORMANCE BONUS PAYMENTS.—

(A) INCREASED FEDERAL SHARE.—With respect to each of fiscal years 2023 through 2026, in each case of the 50 States or the District of Columbia (each referred to in this subsection as a ‘State’) that—

(i) equals or exceeds the qualifying amount (as established by the Secretary) for lower than expected aggregate medical assistance expenditures (as defined in paragraph (4)) for that fiscal year; and

(ii) submitted, submits to the Secretary—

(A) information on the applicable quality measures identified under paragraph (3) with respect to each category of Medicaid eligible individuals (as defined in the State plan or a waiver of such plan; and

(B) a plan for spending a portion of additional funds resulting from application of this subsection on quality improvements within the State plan under this title or under a waiver of such plan, the Federal matching percentage otherwise applicable to such fiscal year (as defined in the State plan or a waiver of such plan) for such fiscal year shall be increased by such percentage (as determined by the Secretary) so that the aggregate amount of the resulting increase pursuant to this subsection for the State and fiscal year does not exceed the State allotment established under paragraph (2) for the State and fiscal year.

(2) ALLOTMENT.—The Secretary, in accordance with such manner and format as specified by the Secretary and for the performance period (as defined by the Secretary) for such fiscal year, shall—

(A) such an allotment to a State is determined based on the performance, including improvement, of such State under this title and the responsiveness to the quality measures submitted under paragraph (3) by State for the performance period (as defined by the Secretary) for such fiscal year; and

(B) the total of the allotments under this paragraph for all States for the period of the fiscal year specified in paragraph (1) is equal to $8,000,000,000.

(3) QUALITY MEASURES REQUIRED FOR BONUS PAYMENTS.—For purposes of this subsection, the Secretary shall, pursuant to rulemaking and after consultation with State agencies administering State plans under this title, identify and publish (and update at such frequency as the Secretary determines necessary) peer-reviewed quality measures (which shall include health care and long-term care outcome measures and quality measures that are developed or overseen or developed by the National Committee for Quality Assurance or the Agency for Healthcare Research and Quality or that are identified under section 1932, or 1115(a)(2) of the Social Security Act (42 U.S.C. 1396a(b), 1396a-2, 1315(a)(1)) as of January 1, 2017; and

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

(B) CHBS WAIVERS.—The Secretary of Health and Human Services shall implement provision of care, services, or benefits under section 1915(b) or 1932, or 1115(a)(2) of the Social Security Act (42 U.S.C. 1396b, 1396a-2, 1315(a)(1)) as of January 1, 2017; and

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

SEC. 135. GRANDFATHERING CERTAIN CHIPS WAIVERS; PRIORITIZATION OF HCBS WAIVERS. (a) MANAGED CARE WAIVERS.—

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

"SEC. 1904A. No proposed rule (as defined in section 554(4) of title 5, United States Code) implementing any provision of this title that take into account the clinically appropriate measures of quality for different types of care is approved by the Secretary of Health and Human Services under section 1915(b), or (4) lower than expected aggregate medical assistance expenditures.——In this subsection, the term ‘lower than expected aggregate medical assistance expenditures’ means, with respect to a State the amount (if any) by which—

(A) the amount of the adjusted 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); and

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

(b) HCBS WAIVERS.—The Secretary of Health and Human Services shall implement provision of care, services, or benefits under section 1915(b) or 1932, or 1115(a)(2) of the Social Security Act (42 U.S.C. 1396b, 1396a-2, 1315(a)(1)) as of January 1, 2017; and

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

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:

"SEC. 1904A. No proposed rule (as defined in section 554(4) of title 5, United States Code) implementing any provision of this title that take into account the clinically appropriate measures of quality for different types of care is approved by the Secretary of Health and Human Services under section 1915(b), or (4) lower than expected aggregate medical assistance expenditures.——In this subsection, the term ‘lower than expected aggregate medical assistance expenditures’ means, with respect to a State the amount (if any) by which—

(A) the amount of the adjusted 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); and

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

(b) HCBS WAIVERS.—The Secretary of Health and Human Services shall implement provision of care, services, or benefits under section 1915(b) or 1932, or 1115(a)(2) of the Social Security Act (42 U.S.C. 1396b, 1396a-2, 1315(a)(1)) as of January 1, 2017; and

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

SEC. 137. OPTIONAL ASSISTANCE FOR CERTAIN INPATIENT PSYCHIATRIC SERVICES. (a) STATE OPTION.—Section 1905 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) in paragraph (16)—

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

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

(B) in the subdivision (B) that follows paragraph (2) and

(C) subject to subsection (h)(4), qualified inpatient psychiatric hospital services (as defined in subsection (h)(3)) for individuals who are over 21 years of age and under 65 years of age; and

(B) the subdivision (B) that follows paragraph (29), by inserting ‘‘or other than services described in paragraph (C) of paragraph (1) of section 1905(a) (as defined in sub-subparagraph after ‘‘patient in an institution for mental diseases’’; 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

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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)(16)(A) and are furnished—

"(A) in an institution (or distinct part thereof) which is a psychiatric hospital (as defined in section 1861(f)); 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 services under subsection (a)(16)(C), the State must—

(a) during the period in which it furnishes medical assistance under this title for services and individuals described in such subsection—

"(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 for inpatient psychiatric hospital services in an institution described in paragraph (3)(A), and for active psychiatric care and treatment provided on an outpatient basis, that is not less 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.".

SEC. 138. ENHANCED FMAP FOR MEDICAL ASSISTANCE FOR ELIGIBLE INDIANS.

Title XIX of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following:

"(c) FEDERAL COST-SHARING ASSISTANCE DEFINED.—

"(1) IN GENERAL.—For purposes of this section, the term 'cost-sharing assistance' includes amounts expended for all or part of the costs of premiums, deductibles, coinsurance, copayments, or similar charges, and all or part of any amounts paid for medical care (within the meaning of section 223(b) of the Internal Revenue Code of 1986).

"(2) OPTION OF ADDITIONAL BENEFITS.—Such term may include, at the option of the State, such additional benefits as the State may specify.

"(d) COST-EFFECTIVE DEFINED.—

"(1) IN GENERAL.—For purposes of this section, the term 'cost-effective' with respect to a State means—

"(i) the Federal average medical assistance percentage shall be 50 percent with respect to medical assistance for services and individuals described in subsection (a)(16)(C).

"(ii) the aggregate amount of Federal cost-sharing and premium assistance (as defined in paragraph (2)) for the State and year do not exceed the Federal cost-sharing assistance limit (as defined in paragraph (3)) for the State and year; and

"(iii) the sum of the products of—

"(A) the Federal average medical assistance matching percentage (as defined in section 1903(a)(4)) for the State and year; and

"(B) the sum of the products of, for each of the years, the sum of

"(i) the Federal medical assistance percentage applicable to the total amount expended for such assistance (as defined in section 1903(a)(4) for such State and year); and

"(ii) the amount of Federal payments made to a State for a year with respect to amounts expended for such assistance (as defined in section 1903(a)(4) for such State and year).

"(2) AGGREGATE AMOUNT OF FEDERAL COST-SHARING AND PREMIUM ASSISTANCE.—The term 'aggregate amount of Federal cost-sharing and premium assistance' means, for a State and year, the product of—

"(A) the Federal average medical assistance matching percentage (as defined in section 1903(a)(4)) for the State and year; and

"(B) the amount of Federal expenditures attributable to advance payments for premium tax credits under subsection (d) of section 1956 of the Internal Revenue Code of 1986 and the Patient Protection and Affordable Care Act made on behalf of eligible low-income individuals in the State for the year.

"(3) FEDERAL COST-SHARING ASSISTANCE LIMIT.—The term 'Federal cost-sharing assistance limit' means, for a State and year, the product of—

"(A) the Federal medical assistance percentage applicable to the total amount expended for such assistance; and

"(B) the Federal medical assistance percentage applicable to the total amount expended for such assistance (as defined in section 1903(a)(4) for such State and year).

"(4) NONAPPLICATION OF OTHER REQUIREMENTS.—Sections 1902(a)(1) (relating to status as an entity); 1916, and 1916A (relating to comparability); 1902(a)(10)(B) (relating to statewideness); 1902(a)(19)(A) (relating to the amendment to state plans that became effective on October 1, 1974), and 1911d of the Social Security Act (42 U.S.C. 300gg-91) shall not apply to the provision of cost-sharing assistance under this section.

"(5) NONAPPLICATION OF OTHER REQUIREMENTS.—Sections 1902(a)(1) (relating to status as an entity); 1916, and 1916A (relating to comparability); 1902(a)(10)(B) (relating to statewideness); 1902(a)(19)(A) (relating to the amendment to state plans that became effective on October 1, 1974), and 1911d of the Social Security Act (42 U.S.C. 300gg-91) 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 qualified health plan (as defined in section 732(h)(1) of the Employee Retirement Income Security Act of 1974) shall be treated as a small group health plan (as defined in section 9831(b)(1) of the Employee Retirement Income Security Act of 1974) for purposes of applying sections 4980B and 5000 and chapter 100 of the Internal Revenue Code of 1986.

(b) RULES.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 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

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

"(1) is a qualified sponsor and receives certification by 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 721 organization; and

"(5) shall not be appropria—"
(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 under which the Secretary—

(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 504, 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 with respect to such plan.

(2) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part must meet 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 issue such final rule requirements 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 termination.

(4) FILING NOTICE OF CERTIFICATION WITH STATE.—A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of 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 for failure to act on an application pursuant to paragraph (1) of up to the applicable fine of the Administration, if the Secretary determines that the application for certification of such small business health plan sponsor was willfully or with gross negligence incomplete or inaccurate.

SEC. 803. PARTICIPATION AND COVERAGE REQUIREMENTS.

(1) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan—

(A) each participating employer must be—

(i) a member of the sponsor;

(ii) the sponsor; or

(iii) 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 are in partnership with individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

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

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

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

(2) INFORMATION REGARDING ALL COVERAGE OPTIONS.—In applying requirements relating to coverage renewal, a participating employer shall not be deemed to be a plan sponsor.

(3) REQUIREMENTS FOR CERTIFIED PLAN SPONSORS.—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 certified until such time as the Secretary may deny for cause the application for certification.

(4) PLAN SPONSOR.—The term ‘plan sponsor’ means the sponsor of a small business health plan, upon receipt of an application that includes the information described in paragraph (2).

(5) INDIVIDUAL MARKET.—

(A) IN GENERAL.—The term ‘individual market’ means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(B) TREATMENT OF VERY SMALL GROUPS.—

(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

(6) PARTICIPATING EMPLOYER.—The term ‘participating employer’ means, in connection with a small business health plan, any employer who, 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 (or 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, partner or employed individual in relation to the plan.

(7) SECTION 7705 ORGANIZATION.—The term ‘section 7705 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 part of a section 7705 organization control group. For purposes of this part, any reference to ‘member,’ shall include a customer of a section 7705 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:

(1) The provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude a health insurance issuer from offering health insurance coverage in connection with a small business health plan which is certified under part 8.  

(2) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following:

Such term also includes a person serving as the sponsor of a small business health plan under part 8.  

(S) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting “or part 8” after “this part”.

(E) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all rules necessary for the implementation of the amendments made by this section within 6 months after the date of the enactment of this Act.
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 and 2019”;

(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) $4,972,000,000 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 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 (3) 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. 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 2701(c)) as the State may determine.”

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

Section 2702(b) of the Public Health Service Act (42 U.S.C. 300gg–2(b)) is amended by adding at the end the following:

“(4) SUNSET.—Paragraphs (1) through (3) and subsection (d) shall not apply for plan years beginning on or after January 1, 2019, and any reference in such paragraphs and subsection shall have no force or effect.

“(5) MEDICAL LOSS RATIO DETERMINED BY THE STATE.—For plan years beginning on or after January 1, 2019, each State shall—

“(A) set the ratio of the amount of premium revenue a health insurance issuer offering group or individual 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 expended by 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 FOR THE WARTIME 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 the period at the end.

(b) CREDIBLE COVERAGE REQUIREMENT.—Section 2702(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–2(b)(2)) is amended by striking “paragraph (3)” and inserting “paragraph (4)”.

(c) APPLICATION OF WAITING PERIODS.—Section 2702(b) of the Public Health Service Act (42 U.S.C. 300gg–1(b)) is amended—

(1) in paragraph (3)—

(A) by striking “with respect to enrollment periods under paragraphs (1) and (2),”;

(B) by redesignating such paragraph as paragraph (4); and

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

“(8) WAITING PERIODS.—

“(A) IN GENERAL.—A health insurance issuer may impose a 6 month waiting period (as defined in section 2704(b)(1) for group health plans) on any individual who enrolls in such coverage and who cannot demonstrate—

“(i) the first day of the first month that an individual enrolls in such coverage during an open enrollment period,

“(ii) 12 months of continuous creditable coverage as described in clause (i); or

“(iii) at least 1 day of creditable coverage during the 60-day period immediately preceding the date of submission of such application.

“(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.—For purposes of subparagraph (A)—

“(i) in the case of an individual that submits an application during an open enrollment period or under a special enrollment period—

“(I) 12 months of continuous creditable coverage as described in clause (i); or

“(II) in the case of an individual submitting an application during a special enrollment period—

“(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; and

“(II) the case of an individual that submits an application outside of an open enrollment period and does not qualify for enrollment under a special enrollment period, coverage under the plan begins on the later of—

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

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

“(D) CERTIFICATES OF CREDITABLE 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 creditable 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.

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

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

“(ii) includes membership in a health care sharing ministry (as defined in section 5000A(d)(2)(B) of the Internal Revenue Code of 1986).

“(F) EXCEPTIONS.—Notwithstanding subparagraph (A), a health insurance issuer may not impose a waiting period with respect to the following individuals—

“(I) A newborn who is enrolled in such coverage within 30 days of the date of birth.

“(II) A child who is adopted or placed for adoption before attaining 18 years of age and is enrolled in such coverage within 30 days of the date of the adoption.

“(III) Other individuals, as the Secretary determines appropriate.

“(G) ADDITIONAL FUNDING.—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, in addition to the requirements described in paragraph (2) that are waived; and

“(H) provide for alternative means of, and requirements for, ensuring comprehensive coverage, reducing average premiums, providing consumers the freedom to purchase the health insurance of their choice, and increasing enrollment in private health insurance; and

“(I) in clause (ii), by striking “that is budget neutral for the Federal Government” and inserting “, demonstrating that the State plan does not increase the Federal deficit”;

“(ii) by adding after the second sentence the following: “A State may request that all of, or any portion of, such aggregate amount of such credits or reductions be paid to the State as described in the first sentence.”;

“(ii) in the paragraph heading, by striking “Plan Year Funding” and inserting “Funding”;

“(i) by striking “With respect” and inserting “Through”;

“(ii) by striking “funding” and inserting “a law or has in effect a certification”;

“(ii) by adding at the end the following:

“(A) ADDITIONAL FUNDING.—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, $2,000,000,000 for fiscal year 2017, to remain available until the end of fiscal year 2019, to provide grants to States for purposes of submitting an application for a waiver granted under this section and implementing the State plan under such waiver.

“(B) AUTHORITY TO USE LONG-TERM STATE INNOVATION AND STABILITY ALLOTMENT.—If the State has an application for an allotment under section 2105(i) of the Social Security Act for the plan year, the State may use the funds available under the State’s allotment for the plan year to carry out such allotment under section 2105(i) of the Social Security Act for the plan year to carry out such allotment.”
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 address an urgent emergency situation with respect to health
insurance coverage within a State.” ;
(2) in subsection (b), in paragraph—
(i) in the matter preceding subparagraph (A)—
(1) by striking “may” and inserting
“shall”; and
(II) by striking “only if” and inserting
“unless”;
and
(ii) describing “plan” and all that follows through the period at the end of sub-
paragraph (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 sub-
section (a)(3)(B);” ; and
(3) in subparagraph (B)—
(i) in the paragraph heading, by inserting
“or CERTIFY” after “LAW” ;
(ii) in subparagraph (A), by inserting be-
fore there is a certificate described in this
paragraph is a document, signed by the Governor, and the State insurance
commissioner, of the State, that provides
the reasons therefore” and inserting “and
the State.” ;
and
(III) by striking “part” each place such term appears; and
(4) in subsection (d)(2)(B), by striking “OF OPT OUT” ;
and
(II) by striking “approve a law” and all that follows through the period at the end
and inserting the following: “may terminate
the authority provided under the waiver
with respect to the State by—
(i) repealing a law described in subpara-
graph (A); or
(iii) terminating the certification described in
subparagraph (A), through a certification for such termination signed by the Governor,
and the State insurance commissioner, of the State.” ;
(5) in subsection (d)(2)(B), by striking “and the reasons therefore” and inserting “and
the reasons therefore, and provide the data
on which such determination was made” ; and
(4) in subsection (e), by striking “No waiver
and all that follows through the period at the end and inserting the following: “A
waiver under this section—
“(1) shall be in effect for a period of 8 years
unless the State requests a shorter duration;
“(2) may be renewed for unlimited addi-
tional 8-year periods upon application by the
State; and
“(3) may not be cancelled by the Secretary before the expiration of the 8-year period (in-
cluding any renewal period under paragraph
(2)).”;.
(b) APPLICABILITY.—Section 1332 of the Pa-
tient Protection and Affordable Care Act (42 U.S.C. 18022(d)(1)) and one health plan that
also offers at least one silver level qualified health plan (as de-
scribed in section 1302(d)(1) of the Patient Protection and Affordable Care Act, 42 U.S.C.
18022(d)(1)) and one health plan that provides the level of coverage described in section
36B(b)(2)(B)(i) of the Internal Rev-

SEC. 209. APPLICATION OF ENFORCEMENT PEN-
ALTIES.—(a) IN GENERAL.—Section 2723 of the Public Health Service Act (42 U.S.C.
300gg-22) is amended—
(1) in subsection (a)—
(A) in paragraph (1), by inserting “and in-
cluding, with respect to plan years beginning
on or after January 1, 2019, enrollees in cata-
strophic plans described in section 1302(e)” after “Coverage” ;
(B) in paragraph (2), by inserting “and in-
cluding, with respect to plan years beginning
on or after January 1, 2019, enrollees in cata-
strophic plans described in section 1302(e)” after “Coverage” ;
and
(2) in subsection (b)—
(A) in paragraphs (1) and (2)(A), by insert-
ing “or section 1303 of the Patient Protec-
tion and Affordable Care Act” after “this
part”; and
(B) in paragraph (2), by inserting “or in such section 1303” after “this part”; and
and
(3) in subsection (c), by inserting “(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 address an urgent emergency situation with respect to health
insurance coverage within a State.” ;
(b) EFFECT OF WAIVER.—A State waiver pursuant to section 1332 of the Patient
Protection and Affordable Care Act (42 U.S.C.
18022) shall not affect the authority of the Secretary to impose penalties under section
2723 of the Public Health Service Act (42 U.S.C.
300gg-22).

SEC. 210. FUNDING FOR COST-SHARING PAY-
MENTS.—There is appropriated to the Secretary of
Health and Human Services, out of any
money in the Treasury not otherwise appro-
priated, such sums as may be necessary for
funds are available under subsection (h)(6) of
section 2105 of the Social Security Act (42 U.S.C.
1397ee), a health insurance issuer (as
defined in section 2791(b)(2) of the Public Health Service Act (42 U.S.C.
300gg(a)(2)), the provisions described in subsection (c) shall be treated as not applying
(directly or through reference) for those plan years
covered before the expiration of the 8-year period, and
(b) E FFECTIVE DATE.—The repeal made by
section 208 shall apply to the Exchange on May 3 of the calendar year preceding the
plan year involved—
(1) certifies to the Secretary and the appli-
cant, and the applicable State health insurance
affiliate that such issuer will apply subsection (a) with re-
spect to health insurance coverage in a rat-
ing area within a State for such plan year; and
(2) certifies to the Secretary that such issuer will make available through the Ex-
change in the rating area in the State in such plan year at least one gold level and
one silver level qualified health plan (as de-
scribed in section 1302(d)(1) of the Patient Protection and Affordable Care Act, 42 U.S.C.
18022(d)(1)) and one health plan that
provides the level of coverage described in section
36B(b)(2)(B)(i) of the Internal Rev-
(c) NON-APPLICABLE PROVISIONS DE-
scribed.—The provisions described in this
subsection are the following:
(1) Subsections (b), (c)(1)(B), and (d) of sec-
tion 1392 of the Patient Protection and Af-
fordable Care Act (42 U.S.C. 18022).
(2) Section 2701(a)(1) of the Public Health
and Human Services Act (42 U.S.C.
300gg(a)(1)).
(3) Section 2702 of the Public Health Service Act (42 U.S.C.
300gg-1).
(4) Section 2704 of the Public Health
Service Act (42 U.S.C.
300gg-3).
(5) Subsections (a) through (j) of section
2705 of the Public Health Service Act (42 U.S.C.
§ 300gg-4).
(6) Section 2707 of the Public Health
Service Act (42 U.S.C.
300gg-6).
(7) Section 2708 of the Public Health
Service Act (42 U.S.C.
300gg-7).
(8) Section 2713(a) of the Public Health
Service Act (42 U.S.C.
300gg-13(a)).
(9) Section 2713(b)(1) of the Public Health
Service Act (42 U.S.C.
§ 300gg-18(b)(1)).
(d) CONTINUOUS COVERAGE.—For purposes of
section 2702(b) of the Public Health Serv-
ces Act (42 U.S.C.
300gg-1), health insurance coverage offered off the Exchange in accord-
ance with subsection (a) shall not be deemed
continuous coverage under section
2701(c) of the Public Health Service Act (42 U.S.C.
300gg-3(c)).
(e) NONAPPLICATION OF RISK ADJUSTMENT
PROVISIONS.—Section 3900 of the Patient
Protection and Affordable Care Act (42 U.S.C.
18065) shall not apply to health insurance
(continued...
coverage offered off the Exchange in accordance with subsection (a) or to the issuer of such coverage with respect to that coverage.

(f) EFFECT OF WAIVER.—A State that receives a waiver of the applicable years beginning after December 31, 2019.

SEC. 102. PREMIUM TAX CREDIT.

(a) IN GENERAL.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986 is amended by—

(1) in paragraph (3), by striking "2.5 percent" and inserting "Zero percent", and (ii) (XX), by inserting "and ending December 31, 2019," after "January 1,

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

SEC. 106. FEDERAL PAYMENTS TO STATES.

(a) IN GENERAL.—Notwithstanding section 501(a), 1902(a)(23), 1903(a), 2001(a), 2005(a)(4), or 2101(a), 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 is that considered direct spending for any year may be made available to a State for payments to a prohibited health care provider.

(b) DEFINITIONS.—In this section:

(1) PROHIBITED ENTITY.—The term "prohibi-

The amendment made by this subsection shall apply to months beginning after December 31, 2015.

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

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

"(C) in subsection (z)(2)—

"(ii)(VIII) and (ii)(XX), by inserting "and ending December 31, 2019," after "January 1, 2019.";

"(ii) in paragraph (3)—

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

"(E) EFFECTIVE DATE.—The amendment made by 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 subsection:

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

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

SEC. 104. INDIVIDUAL MANDATE.

(a) IN GENERAL.—Section 9001(a)(c) of the Internal Revenue Code of 1986 is amended—

(1) in paragraph (3)(A)(ii), by striking "2.5 percent" and inserting "Zero percent", and

(b) EFFECTIVE DATE.—The amendments made by this subsection 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, 2019)" after "$2,000."

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

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2019.
(i) in subparagraph (A), by inserting “through 2019” after “each year thereafter”;

(ii) in subparagraph (B)(v), by striking “and subsequent year”;

(iii) in section 1915(k)(2), by striking “during the period described in paragraph (1)” and inserting “or after the date referred to in paragraph (1) before January 1, 2020”;

(iv) in section 1920(e), by adding at the end the following: “This subsection shall not apply after December 31, 2019.”;

(v) 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. 1396n-4(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 4980H.

(b) Effective Date.—The amendment made by subsection (a) shall apply with respect to taxable years beginning after December 31, 2019.

(c) REPEAL.—The amendment made by subsection (a) shall not apply to taxable years beginning after December 31, 2020, and before December 31, 2023.

(d) Effective Dates.—The amendment made by this section shall apply—

(1) DISTRIBUTIONS FROM SAVINGS ACCOUNTS.—The amendments made by subsection (a), to the extent applicable to any cost taken into account in determining any deduction is allowable with respect to any cost taken into account in determining such payment,

(2) REIMBURSEMENTS.—The amendment made by subsection (a), to the extent applicable to such individual with respect to expenses incurred with respect to taxable years beginning after December 31, 2017.

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

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 MSA.—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 106 of the Internal Revenue Code of 1986 is amended by striking subsection (l).

(d) EFFECTIVE DATES.—The amendments made by subsection (c) shall apply to amounts paid 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 “15 percent”.

(b) ARCHER MSA.—Paragraph (A) of 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 amounts paid with respect to taxable years beginning after December 31, 2018.

SEC. 112. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO FLEXIBLE SPENDING ARRANGEMENTS.

(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 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 new subsection:

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

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 SUBTRACTION MEDICATIONS.

(a) In General.—Section 220 of the Internal Revenue Code of 1986 is amended by striking “20 percent” and inserting “15 percent”.

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

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

SEC. 117. MEDICARE PART D SUBSIDY.

(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. 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) Tax.—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 with respect to employment (as defined in section 3121(b)).”

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

SEC. 119. REMUNERATION.

(a) GENERAL.—Subtitle A of the Internal Revenue Code of 1986 is amended by striking chapter 43 and all that follows through the period.

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

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, 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, 2020.

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) by striking “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 monies in the Treasury not otherwise obligated, $350,000,000 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 a higher prevalence of substance abuse and mental health disorders that is substantial relative to other States or to States that identify mental health needs within their communities that are urgent relative to such needs and State 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.

(5) Other 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. 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. 43) paragraph (1) of section 221(a) of such Act is amended by inserting “, and an additional $222,000,000 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, 2020, as the ninth and final payment under section 1010 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.

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, 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. 1. SUNSET OF THE PATIENT PROTEC-
TION AND AFFORDABLE CARE ACT.

(a) In General.—Section 1302(d)(3)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(d)(3)(B)) is amended—

(1) by striking the matter proposed to be inserted, insert the following:

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In title VI, after the amendments made by such Act, the definition of ‘“United States Code’’ is amended by striking ‘“United States Code”’.

(2) by striking the matter proposed to be inserted, insert the following:

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In title VI, after the amendments made by such Act, the definition of ‘“United States Code”’.

(3) by striking the matter proposed to be inserted, insert the following:

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In title VI, after the amendments made by such Act, the definition of ‘“United States Code”’.

(4) by striking the matter proposed to be inserted, insert the following:

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In title VI, after the amendments made by such Act, the definition of ‘“United States Code”’.

(5) by striking the matter proposed to be inserted, insert the following:

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In title VI, after the amendments made by such Act, the definition of ‘“United States Code”’.

(6) by striking the matter proposed to be inserted, insert the following:

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In title VI, after the amendments made by such Act, the definition of ‘“United States Code”’.

(7) by striking the matter proposed to be inserted, insert the following:

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In title VI, after the amendments made by such Act, the definition of ‘“United States Code”’.

(8) by striking the matter proposed to be inserted, insert the following:

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In title VI, after the amendments made by such Act, the definition of ‘“United States Code”’.

(9) by striking the matter proposed to be inserted, insert the following:

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In title VI, after the amendments made by such Act, the definition of ‘“United States Code”’.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Before the passage of the Patient Protection and Affordable Care Act (Public Law 111–14) 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 uninsured 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 111–14), Americans 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 health 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 payments 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 gain access to high-quality health care.

(7) Risk mitigation programs, such as the reinsurance program for the Medicare Part D prescription drug benefit program, have provided additional stability to 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 to stabilize the health insurance marketplaces and reduced insurance premiums in the individual health insurance market by as much as 10 percent.

(9) Throughout his Presidential campaign, the President of the United States repeatedly promised the American people that his health care plan will result in reduced rates of uninsured, lower in quality care, stating on January 14, 2017, that “We’re going to have insurance for everybody. There was a philosophy in some circles that if you can’t pay for it, you can’t get it. That’s not going to happen with us”; and on January 25, 2017, that “I can assure you, we are going to have insurance for everybody. There was a philosophy in some circles that if you can’t pay for it, you can’t get it. That’s not going to happen with us”. 

Mr. BARRASSO 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. 1. 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)(ii) of the Internal Revenue Code of 1986 is amended by striking “$2,250” and inserting “the amount in effect under subsection (c)(2)(A)(i)(II)”.

(b) FAMILY.—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)(i)(II)”.

(c) COST-OF-LIVING ADJUSTMENT.—Section 223(g)(1) of such Code is amended—

(1) by striking “(b) and (c)” and inserting “section”, and

(2) by striking paragraph (b), by striking “determined by” and all that follows through “calendar year 2003”, and inserting “determined by subtracting ‘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.

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, 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. 1. ALLOWING ALL INDIVIDUALS PURCHASING HEALTH INSURANCE IN THE INDIVIDUAL MARKET THE OPPORTUNITY TO PURCHASE A LOWER PREMIUM CATASTROPHIC PLAN.

(a) In General.—Section 1302(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(e)) is amended by adding at the end the following:

“(d) CONSUMER FREEDOM.—For plan years beginning on or after January 1, 2019, paragraph (1)(A) shall not apply with respect to any plan offered in the State.”;

(b) RISK POOLS.—Section 1312(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(c)) is amended—

(1) in paragraph (1), by inserting “and including, with respect to plan years beginning on or after January 1, 2019, enrollees in catastrophic plans described in section 1302(e)” after “Exchange”;

(2) in paragraph (2), by inserting “and including, with respect to plan years beginning on or after January 1, 2019, enrollees in catastrophic plans described in section 1302(e)” after “Exchange”.

SA 276. Mr. KAINÉ (for himself, Mr. CARPER, Mr. COONS, Mrs. SHAHEEN, Mr. CARDIN, Ms. HASSAN, Ms. KLOBUCHAR, 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:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Individual Health Insurance Marketplace Improvement Act”.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Before the passage of the Patient Protection and Affordable Care Act (Public Law 111–14) 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 uninsured 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 111–14), Americans 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 health 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 payments 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 gain access to high-quality health care.

(7) Risk mitigation programs, such as the reinsurance program for the Medicare Part D prescription drug benefit program, have provided additional stability to 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 to stabilize the health insurance marketplaces and reduced insurance premiums in the individual health insurance market by as much as 10 percent.

(9) Throughout his Presidential campaign, the President of the United States repeatedly promised the American people that his health care plan will result in reduced rates of uninsured, lower in quality care, stating on January 14, 2017, that “We’re going to have insurance for everybody. There was a philosophy in some circles that if you can’t pay for it, you can’t get it. That’s not going to happen with us”; and on January 25, 2017, that “I can assure you, we are going to have a better plan, much better health care, than we ever have had before, a plan where you can have access to the doctor that you want and the plan that you want. We’re
(10) The goal of any health care legislation should be to build on the Affordable Care Act to continue coverage and make health care more affordable for Americans. Improving affordability and expanding coverage will also broaden the individual market and stabilize premiums 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 (e)) for each calendar year beginning after January 1, 2018, of the amount specified under subparagraph (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.

(b) Individual Market Reinsurance Program.—
(1) Use of funds.—The Secretary shall use amounts appropriated to 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 and 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 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 to enroll in 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 and cost-sharing reductions.—To distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium assistance and cost-sharing reductions under section 1521 of the Patient Protection and Affordable Care Act.

(2) Amount of payment.—The payment made to a health insurance issuer under subsection (a) with respect to high-cost individuals enrolled in qualified health plans and offered by such issuers that are not grandfathered health plans or transitional health plans shall be 80 percent of the lesser of:

(A) the amount that is necessary to carry out this subsection.

(B) The amount 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 to enroll in 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 and cost-sharing reductions.—To distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium assistance and cost-sharing reductions under section 1521 of the Patient Protection and Affordable Care Act.

(d) Grant application.—The application for funds under this section shall specify the following:

(A) A description of the program or services for which funds are requested.

(B) A description of the methods and procedures that will be used to verify the eligibility of individuals for the assistance or services.

(C) A description of the methods and procedures that will be used to ensure that the assistance or services are provided in a manner that is accessible to eligible individuals.

(D) A description of the methods and procedures that will be used to oversee the use of funds under this section.

(e) Eligible entities defined.—
(1) In general.—In this section, the term “eligible entity” means—

(A) a State; or

(B) a nonprofit community-based organization.

(f) 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.

(g) Exclusions.—Such term does not include an entity that—

(A) is a health insurance issuer; or

(B) receives any consideration, either directly or indirectly, from any health insurance issuer in connection with the enrollment of eligible individuals employed or otherwise associated with a qualified employer in a qualified health plan.

(h) 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 rating areas at risk of having no qualified health plans in the individual market.

(i) Funding.—Out of any moneys in the Treasury not otherwise appropriated, such sums as may be necessary to carry out this subsection.

(j) Reports to Congress.—
(1) Initial report.—The Secretary shall submit a report to Congress, not later than January 21, 2019, and each year thereafter, that contains the following information for the most recently ended calendar year:

(A) The number and types of plans in each State’s individual market, specifying the number that are qualified health plans, grandfathered health plans, and transitional health plans.

(B) The impact of the reinsurance payments provided under this section on the availability of coverage, cost of coverage, and coverage options in each State.

(C) The amount of premiums paid by individuals in each State by age, family size, geographic area in the State’s individual market, and category of health plan (as described in subparagraph (b)).

(2) Evaluation report.—Not later than January 31, 2022, the Secretary shall submit to Congress a report that—

(A) analyzes the impact of the funds provided under this section on premiums and enrollment in the individual market in all States; and

(B) contains a State-by-State comparison of the difference between the reinsurance programs carried out by States with funds provided under this section and the reinsurance program established under subsection (a).

(k) Definitions.—In this section, the term “Secretary” means the Secretary of the Department of Health and Human Services.

(l) Fund.—The term “Fund” means the Individual Market Reinsurance Fund established under subsection (a).

(m) Grandfathered health plan.—The term “grandfathered health plan” has the meaning given to it under section 1302(c)(4) of the Patient Protection and Affordable Care Act.

(n) High-cost individuals.—The term “high-cost individuals” means individuals enrolled in a qualified health plan (other than a grandfathered health plan or a transitional health plan) who incur claims in excess of $500,000 during a plan year.

(o) State.—The term “State” means each of the 50 States and the District of Columbia.

(p) Transitional health plan.—The term “transitional health plan” means a plan or in a State Medicaid program, as appropriate.

(q) Transitional health program.—The term “transitional health program” means a program of the State Medicaid program, as appropriate.

(r) Secrecy flexibility for budget neutral revisions to reinsurance payment specifications.—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.
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:

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 the County of Fairfax, 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) Marshall Drive to the south; and
(4) North Meade Street to the west.

(b) ESTABLISHMENT OF VISITOR SERVICES FACILITY.—Notwithstanding section 2863(c) of the National Park Service Monument and Memorial Improvement Act for Fiscal Year 2002 (Public Law 107–197; 115 Stat. 1332), the Secretary of the Interior may construct a structure for visitor services, hereunder this facility, 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 3104B of title 10, United States Code, is amended—

(1) by striking "issued under" and inserting the following: "issued—

under this section, and such provisions of such section solely to the extent related to the application of the last sentence of subsection (e)(4)(A)(i)"; and

(2) by striking "requirements." and inserting "requirements; and"; and

(3) 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. 16. PROTECTION OF SECOND AMENDMENT RIGHTS.

(a) Ensuring the Quality of Care.—Section 2271(c) of the Public Health Service Act (42 U.S.C. 300gg–17(c)) is amended by inserting "or, the Better Care Reconciliation Act of 2017 or an amendment made by that Act, after the 1-year period beginning on the date of enactment of such Act or an amendment made by that Act " each place that term appears.

(b) 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 or enter 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 under section 933 of 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."
(ii) is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in providing a medical, health, and related medical care; and (iii) provides for abortions, other than an abortion—

(i) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, or the consequences of pregnancy itself;

(ii) in the case where the woman would be placed in danger of death or severe bodily injury by or from any actual or threatened physical harm due to her pregnancy unless an abortion is performed, including a life-endangering physical condition caused by or resulting from the pregnancy; and

(iii) in the case where the female parent of the child has been physically abused.

SEC. 108. REPEAL OF DSH ALLOTMENT REDUCTIONS.
Section 1923(f) of the Social Security Act (42 U.S.C. 1396d(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, 2015.

(c) SUBSEQUENT EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2016.

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

(c) HRA.—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.

(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, 2017.

(2) REMISSIONS.—The amendment made by subsection (c) shall apply to remissions made after December 31, 2017.

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

(c) EFFECTIVE DATE.—The amendments made by 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 plan years beginning after December 31, 2016.

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—

(1) apply to calendar years beginning after December 31, 2010, and ending on January 1, 2018; and

(2) apply to each subsequent year.”

SEC. 114. REPEAL OF MEDICAL DEVICE EXCISE TAX.
Section 4319A of the Internal Revenue Code of 1986 is amended by striking “3 percent” and inserting “10 percent”.

SEC. 115. REPEAL OF HEALTH INSURANCE TAX.
Subsection (j) of section 9010 of the Patient Protection and Affordable Care Act is amended by striking “health crisis or to respond to urgent mental health crisis”, and at the end thereof inserting “and 2019”.

SEC. 116. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.
(a) IN GENERAL.—Subsection (o) of the Internal Revenue Code of 1986 is amended by striking “and” and at the end thereof inserting “and ending December 31, 2015.”

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

SEC. 117. 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 “20 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 1.5 percent of the wages (as defined in section 3121(a)) received by such individual with 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 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 December 31, 2016.

SEC. 121. REMUNERATION.
Paragraph (6) of section 163(m) of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new paragraph:

“(l) REMUNERATION.—This paragraph shall not apply to remuneration received after December 31, 2016.”

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. 300g–501) 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 monies 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 substantially relative to other States or to grants that identify unmet needs within their communities that are urgent relative to such needs of other States.
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) Other 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. 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 $222,000,000 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 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.

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, 2020.

AUTHORITY FOR COMMITTEES TO MEET
Mr. ENZI. Mr. President, I have 7 requests for committees to meet during today’s session of the Senate. They 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.”
To be lieutenant general

LT. GEN. ROBERT P. ASHLEY, JR.

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE RESERVE OF THE ARMY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be major general

BRIG. GEN. DARRELL J. GUTHRIE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE RESERVE OF THE ARMY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be brigadier general

COL. BRIAN E. MILLER

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be lieutenant commander

CLAIR E. SMITH

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE REGULAR NAVY UNDER TITLE 10, U.S.C., SECTION 531:

To be lieutenant commander

ANDREW B. BRIDGFORTH

RONALD J. MITCHELL