COMMITTEE PRINT

Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act

TITLE I—ENERGY AND COMMERCE

Subtitle A—Patient Access to Public Health Programs

SEC. 101. THE PREVENTION AND PUBLIC HEALTH FUND.

(a) In General.—Subsection (b) of section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11), as amended by section 5009 of the 21st Century Cures Act, is amended—

(1) in paragraph (2), by adding “and” at the end;

(2) in paragraph (3)—

(A) by striking “each of fiscal years 2018 and 2019” and inserting “fiscal year 2018”; and

(B) by striking the semicolon at the end and inserting a period; and

(3) by striking paragraphs (4) through (8).
(b) Rescission of Unobligated Funds.—Of the funds made available by such section 4002, the unobligated balance at the end of fiscal year 2018 is rescinded.

SEC. 102. COMMUNITY HEALTH CENTER PROGRAM.

Effective as if included in the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10, 129 Stat. 87), paragraph (1) of section 221(a) of such Act is amended by inserting “, and an additional $422,000,000 for fiscal year 2017” after “2017”.

SEC. 103. FEDERAL PAYMENTS TO STATES.

(a) In General.—Notwithstanding section 504(a), 1902(a)(23), 1903(a), 2002, 2005(a)(4), 2102(a)(7), or 2105(a)(1) of the Social Security Act (42 U.S.C. 704(a), 1396a(a)(23), 1396b(a), 1397a, 1397d(a)(4), 1397bb(a)(7), 1397ee(a)(1)), or the terms of any Medicaid waiver in effect on the date of enactment of this Act that is approved under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n), for the 1-year period beginning on the date of the enactment of this Act, no Federal funds provided from a program referred to in this subsection that is considered direct spending for any year may be made available to a State for payments to a prohibited entity, whether made directly to the prohibited entity or through a managed care organization under contract with the State.
(b) DEFINITIONS.—In this section:

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

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

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

(ii) is an essential community provider described in section 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 family planning services, reproductive health, and related medical care; and

(iii) provides for abortions, other than an abortion—

(I) if the pregnancy is the result of an act of rape or incest; or

(II) in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician,
place the woman in danger of death
unless an abortion is performed, in-
cluding a life-endangering physical
condition caused by or arising from
the pregnancy itself; and

(B) for which the total amount of Federal
and State expenditures under the Medicaid pro-
gram under title XIX of the Social Security Act
in fiscal year 2014 made directly to the entity
and to any affiliates, subsidiaries, successors, or
clinics of the entity, or made to the entity and
to any affiliates, subsidiaries, successors, or
clinics of the entity as part of a nationwide
health care provider network, exceeded
$350,000,000.

(2) DIRECT SPENDING.—The term “direct
spending” has the meaning given that term under
section 250(c) of the Balanced Budget and Emer-
gency Deficit Control Act of 1985 (2 U.S.C. 900(c)).

Subtitle B—Medicaid Program
Enhancement

SEC. 111. REPEAL OF MEDICAID PROVISIONS.
The Social Security Act is amended—

(1) in section 1902 (42 U.S.C. 1396a)—
(A) in subsection (a)(47)(B), by inserting
“and provided that any such election shall cease
to be effective on January 1, 2020, and no such
election shall be made after that date” before
the semicolon at the end; and

(B) in subsection (l)(2)(C), by inserting
“and ending December 31, 2019,” after “Janu-
ary 1, 2014,”;

(2) in section 1915(k)(2) (42 U.S.C.
1396n(k)(2)), by striking “during the period de-
scribed in paragraph (1)” and inserting “on or after
the date referred to in paragraph (1) and before
January 1, 2020”; and

(3) in section 1920(e) (42 U.S.C. 1396r–1(e)),
by striking “under clause (i)(VIII), clause (i)(IX), or
clause (ii)(XX) of subsection (a)(10)(A)” and insert-
ing “under clause (i)(VIII) or clause (ii)(XX) of sec-
tion 1902(a)(10)(A) before January 1, 2020, section
1902(a)(10)(A)(i)(IX),”.

SEC. 112. REPEAL OF MEDICAID EXPANSION.

(a) IN GENERAL.—Section 1902(a)(10)(A) of the So-
cial Security Act (42 U.S.C. 1396a(a)(10)(A)) is amend-
ed—

(1) in clause (i)(VIII), by inserting “at the op-
tion of a State,” after “January 1, 2014,”; and
(2) in clause (ii)(XX), by inserting “and ending December 31, 2019,” after “2014,.”

(b) TERMINATION OF EFMAP FOR NEW ACA EXPANSION ENROLLEES.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (y)(1), in the matter preceding subparagraph (A), by striking “with respect to” and all that follows through “shall be” and inserting “with respect to amounts expended before January 1, 2020, by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) who are enrolled under the State plan (or a waiver of the plan) before such date and with respect to amounts expended after such date by such State for medical assistance for individuals described in such subclause who were enrolled under such plan (or waiver of such plan) as of December 31, 2019, and who do not have a break in eligibility for medical assistance under such State plan (or waiver) for more than one month after such date, shall be”; and

(2) in subsection (z)(2)—

(A) in subparagraph (A), by striking “medical assistance for individuals” and all that follows through “shall be” and inserting
“amounts expended before January 1, 2020, by such State for medical assistance for individuals described in section 1902(a)(10)(A)(i)(VIII) who are nonpregnant childless adults with respect to whom the State may require enrollment in benchmark coverage under section 1937 and who are enrolled under the State plan (or a waiver of the plan) before such date and with respect to amounts expended after such date by such State for medical assistance for individuals described in such section, who are nonpregnant childless adults with respect to whom the State may require enrollment in benchmark coverage under section 1937, who were enrolled under such plan (or waiver of such plan) as of December 31, 2019, and who do not have a break in eligibility for medical assistance under such State plan (or waiver) for more than one month after such date, shall be” ; and

(B) in subparagraph (B)(ii)—

(i) in subclause (III), by adding “and” at the end; and

(ii) by striking subclauses (IV), (V), and (VI) and inserting the following new subclause:
“(IV) 2017 and each subsequent year is 80 percent.”.

(c) SUNSET OF ESSENTIAL HEALTH BENEFITS REQUIREMENT.—Section 1937(b)(5) of the Social Security Act (42 U.S.C. 1396u–7(b)(5)) is amended by adding at the end the following: “This paragraph shall not apply after December 31, 2019.”.

SEC. 113. ELIMINATION OF DSH CUTS.

Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (7)—

(A) in subparagraph (A)—

(i) in clause (i)—

(I) in the matter preceding subclause (I), by striking “2025” and inserting “2019”; and

(ii) in clause (ii)—

(II) in subclause (II), by striking the semicolon at the end and inserting a period; and

(III) by striking subclauses (III) through (VIII); and
(B) by adding at the end the following new subparagraph:

“(C) EXEMPTION FROM EXEMPTION FOR NON-EXPANSION STATES.—

“(i) IN GENERAL.—In the case of a State that is a non-expansion State for a fiscal year, subparagraph (A)(i) shall not apply to the DSH allotment for such State and fiscal year.

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

“(iii) NON-EXPANSION AND EXPANSION STATE DEFINED.—

“(I) The term ‘expansion State’ means with respect to a fiscal year, a State that, as of July 1 of the preceding fiscal year, provides for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) for medical assistance under this title (or
a waiver of the State plan approved
under section 1115).

“(II) The term ‘non-expansion
State’ means, with respect to a fiscal
year, a State that is not an expansion
State.”; and

(2) in paragraph (8), by striking “fiscal year
2025” and inserting “fiscal year 2019”.

SEC. 114. REDUCING STATE MEDICAID COSTS.

(a) LETTING STATES DISENROLL HIGH DOLLAR
LOTTERY WINNERS.—

(1) IN GENERAL.—Section 1902 of the Social
Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(17), by striking
“(e)(14), (e)(14)” and inserting “(e)(14),
(e)(15)”;

(B) in subsection (e)—

(i) in paragraph (14) (relating to
modified adjusted gross income), by adding
at the end the following new subparagraph:

“(J) TREATMENT OF CERTAIN LOTTERY
WINNINGS AND INCOME RECEIVED AS A LUMP
SUM.—

“(i) IN GENERAL.—In the case of an
individual who is the recipient of qualified
lottery winnings (pursuant to lotteries occurring on or after January 1, 2020) or qualified lump sum income (received on or after such date) and whose eligibility for medical assistance is determined based on the application of modified adjusted gross income under subparagraph (A), a State shall, in determining such eligibility, include such winnings or income (as applicable) as income received—

“(I) in the month in which such winnings or income (as applicable) is received if the amount of such winnings or income is less than $80,000;

“(II) over a period of 2 months if the amount of such winnings or income (as applicable) is greater than or equal to $80,000 but less than $90,000;

“(III) over a period of 3 months if the amount of such winnings or income (as applicable) is greater than or equal to $90,000 but less than $100,000; and
“(IV) over a period of 3 months plus 1 additional month for each increment of $10,000 of such winnings or income (as applicable) received, not to exceed a period of 120 months (for winnings or income of $1,260,000 or more), if the amount of such winnings or income is greater than or equal to $100,000.

“(ii) Counting in Equal Installments.—For purposes of subclauses (II), (III), and (IV) of clause (i), winnings or income to which such subclause applies shall be counted in equal monthly installments over the period of months specified under such subclause.

“(iii) Hardship Exemption.—An individual whose income, by application of clause (i), exceeds the applicable eligibility threshold established by the State, may continue to be eligible for medical assistance to the extent that the State determines, under procedures established by the State under the State plan (or in the case of a waiver of the plan under section 1115,
incorporated in such waiver), or as otherwise established by such State in accordance with such standards as may be specified by the Secretary, that the denial of eligibility of the individual would cause an undue medical or financial hardship as determined on the basis of criteria established by the Secretary.

“(iv) NOTIFICATIONS AND ASSISTANCE REQUIRED IN CASE OF LOSS OF ELIGIBILITY.—A State shall, with respect to an individual who loses eligibility for medical assistance under the State plan (or a waiver of such plan) by reason of clause (i), before the date on which the individual loses such eligibility, inform the individual of the date on which the individual would no longer be considered ineligible by reason of such clause to receive medical assistance under the State plan or under any waiver of such plan and the date on which the individual would be eligible to reapply to receive such medical assistance.

“(v) QUALIFIED LOTTERY WINNINGS DEFINED.—In this subparagraph, the term
‘qualified lottery winnings’ means winnings from a sweepstakes, lottery, or pool described in paragraph (3) of section 4402 of the Internal Revenue Code of 1986 or a lottery operated by a multistate or multijurisdictional lottery association, including amounts awarded as a lump sum payment.

“(vi) QUALIFIED LUMP SUM INCOME DEFINED.—In this subparagraph, the term ‘qualified lump sum income’ means income that is received as a lump sum from one of the following sources:

“(I) Monetary winnings from gambling (as defined by the Secretary and including monetary winnings from gambling activities described in section 1955(b)(4) of title 18, United States Code).

“(II) Income received as liquid assets from the estate (as defined in section 1917(b)(4)) of a deceased individual.”; and

(ii) by striking “(14) EXCLUSION” and inserting “(15) EXCLUSION”.

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

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

(b) **Repeal of Retroactive Eligibility.**—

(1) *In General.—*

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

(B) **Definition of Medical Assistance.**—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by striking “in 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”.

(2) **Effective Date.**—The amendments made by paragraph (1) shall apply to medical assistance with respect to individuals whose eligibility for such assistance is based on an application for such assist-
ance made (or deemed to be made) on or after October 1, 2017.

c) Ensuring States Are Not Forced to Pay for Individuals Ineligible for the Program.—

(1) In General.—Section 1137(f) of the Social Security Act (42 U.S.C. 1320b–7(f)) is amended—

(A) by striking “Subsections (a)(1) and (d)” and inserting “(1) Subsections (a)(1) and (d)”;

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

“(2)(A) Subparagraphs (A) and (B)(ii) of subsection (d)(4) shall not apply in the case of an initial determination made on or after the date that is 6 months after the date of the enactment of this paragraph with respect to the eligibility of an alien described in subparagraph (B) for benefits under the program listed in subsection (b)(2).

“(B) An alien described in this subparagraph is an individual declaring to be a citizen or national of the United States with respect to whom a State, in accordance with section 1902(a)(46)(B), requires—

“(i) pursuant to 1902(ee), the submission of a social security number; or
“(ii) pursuant to 1903(x), the presentation of satisfactory documentary evidence of citizenship or nationality.”.

(2) NO PAYMENTS FOR MEDICAL ASSISTANCE PROVIDED BEFORE PRESENTATION OF EVIDENCE.—

Section 1903(i)(22) of the Social Security Act (42 U.S.C. 1396b(i)(22)) is amended—

(A) by striking “with respect to amounts expended” and inserting “(A) with respect to amounts expended”;

(B) by inserting “and” at the end; and

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

“(B) in the case of a State that elects to provide a reasonable period to present satisfactory documentary evidence of such citizenship or nationality pursuant to paragraph (2)(C) of section 1902(ee) or paragraph (4) of subsection (x) of this section, for amounts expended for medical assistance for such an individual (other than an individual described in paragraph (2) of such subsection (x)) during such period;”.

(3) CONFORMING AMENDMENTS.—Section 1137(d)(4) of the Social Security Act (42 U.S.C. 1320b–7(d)(4)) is amended—
(A) in subparagraph (A), in the matter preceding clause (i), by inserting “subject to subsection (f)(2),” before “the State”; and

(B) in subparagraph (B)(ii), by inserting “subject to subsection (f)(2),” before “pending such verification”.

(d) Updating Allowable Home Equity Limits in Medicaid.—

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

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

(B) by striking subparagraph (B);

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

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

(2) Effective Date.—

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

(B) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act that the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by amendments made by this subsection, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.
SEC. 115. SAFETY NET FUNDING FOR NON-EXPANSION STATES.

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

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

“Sec. 1923A. (a) In General.—Subject to the limitations of this section, for each year during the period beginning with 2018 and ending with 2021, each State that is one of the 50 States or the District of Columbia and that, as of July 1 of the preceding year, did not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) for medical assistance under this title (or a waiver of the State plan approved under section 1115) (each such State or District referred to in this section for the year as a ‘non-expansion State’) may adjust the payment amounts 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 (in this section referred to as ‘eligible providers’).

“(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 (c) shall be equal to—

“(1) 100 percent for calendar quarters in calendar years 2018, 2019, 2020, and 2021; and

“(2) 95 percent for calendar quarters in calendar year 2022.

“(c) LIMITATIONS; DISQUALIFICATION OF STATES.—

“(1) ANNUAL ALLOTMENT LIMITATION.—Payment under section 1903(a) shall not be made to a State with respect to any payment adjustment made under this section for all calendar quarters in a year in excess of the $2,000,000,000 multiplied by the ratio of—

“(A) the population of the State with income below 138 percent of the poverty line in 2015 (as determined based the table entitled ‘Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age’ for the universe of the civilian noninstitutionalized population for whom poverty status is determined based on the 2015 American Community Survey 1-Year Estimates, as published by the Bureau of the Census), to

“(B) the sum of the populations under subparagraph (A) for all non-expansion States.
“(2) LIMITATION ON PAYMENT ADJUSTMENT AMOUNT FOR INDIVIDUAL PROVIDERS.—The amount of a payment adjustment under subsection (a) for an eligible provider may not exceed the provider’s costs incurred in furnishing health care services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) to individuals who either are eligible for medical assistance under the State plan (or under a waiver of such plan) or have no health insurance or health plan coverage for such services.

“(d) DISQUALIFICATION IN CASE OF STATE COVERAGE EXPANSION.—If a State is a non-expansion for a year and provides eligibility for medical assistance described in subsection (a) during the year, the State shall no longer be treated as a non-expansion State under this section for any subsequent years.”.

SEC. 116. PROVIDING INCENTIVES FOR INCREASED FREQUENCY OF ELIGIBILITY REDETERMINATIONS.

(a) IN GENERAL.—Section 1902(e)(14) of the Social Security Act (42 U.S.C. 1396a(e)(14)) (relating to modified adjusted gross income), as amended by section 114(a)(1), is further 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) or clause (ii)(XX) of subsection (a)(10)(A), a State shall redetermine such individual’s eligibility for such medical assistance no less frequently than once every 6 months.”.

(b) CIVIL MONETARY PENALTY.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7(a)) is amended, in the matter following paragraph (10), by striking “(or, in cases under paragraph (3)” and inserting the following: “(or, in cases under paragraph (1) in which an individual was knowingly enrolled on or after October 1, 2017, pursuant to section 1902(a)(10)(A)(i)(VIII) for medical assistance under the State plan under title XIX whose income does not meet the income threshold specified in such section or in which a claim was presented on or after October 1, 2017, as a claim for an item or service furnished to an individual described in such section but
whose enrollment under such State plan is not made on
the basis of such individual’s meeting the income threshold
specified in such section, $20,000 for each such individual
or claim; in cases under paragraph (3)”.

(c) **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 ap-
plicable under section 1903(a) of the Social Security Act
(42 U.S.C. 1396b(a)) with respect to State expenditures
during such quarter that are attributable to meeting the
requirement of section 1902(e)(14) (relating to determina-
tions 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 car-
ried out by the State (and approved by the Secretary) to
increase the frequency of eligibility redeterminations re-
quired by subparagraph (K) of such section (relating to
eligibility redeterminations made on a 6-month basis) (as
added by subsection (a)).

**Subtitle C—Per Capita Allotment for Medical Assistance**

**SEC. 121. PER CAPITA ALLOTMENT FOR MEDICAL ASSIST-
ANCE.**

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 section 1903A(a)” after “except as otherwise provided in this section”; and

(B) in subsection (d)(1), by striking “to which” and inserting “to which, subject to section 1903A(a),”;

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

**SEC. 1903A. PER CAPITA-BASED CAP ON PAYMENTS FOR MEDICAL ASSISTANCE.**

“(a) Application of Per Capita Cap on Payments for Medical Assistance Expenditures.—

“(1) In general.—If a State has excess aggregate medical assistance expenditures (as defined in paragraph (2)) for a fiscal year (beginning with fiscal year 2020), the amount of payment to the State under section 1903(a)(1) for each quarter in the following fiscal year shall be reduced by ¼ of the excess aggregate medical assistance payments (as defined in paragraph (3)) for that previous fiscal year. In this section, the term ‘State’ means only the 50 States and the District of Columbia.
“(2) Excess Aggregate Medical Assistance Expenditures.—In this subsection, the term ‘excess aggregate medical assistance expenditures’ means, for a State for a fiscal year, the amount (if any) by which—

“A) the amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State and fiscal year; exceeds

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

“(3) Excess Aggregate Medical Assistance Payments.—In this subsection, the term ‘excess aggregate medical assistance payments’ means, for a State for a fiscal year, the product of—

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

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

“(4) Federal Average Medical Assistance Matching Percentage.—In this subsection, the term ‘Federal average medical assistance matching
percentage' means, for a State for a fiscal year, the
ratio (expressed as a percentage) of—

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

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

“(b) ADJUSTED TOTAL MEDICAL ASSISTANCE EXP-
ENDITURES.—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 fiscal year 2016, the product of—

“(i) the amount of the medical assist-
ance expenditures (as defined in paragraph
(2)) for the State and fiscal year, reduced
by the amount of any excluded expendi-
tures (as defined in paragraph (3)) for the
State and fiscal year otherwise included in
such medical assistance expenditures; and
“(ii) the 1903A FY16 population percentage (as defined in paragraph (4)) for the State; or

“(B) for fiscal year 2019 or a subsequent fiscal year, the amount 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.

“(2) MEDICAL ASSISTANCE EXPENDITURES.—In this section, the term ‘medical assistance expenditures’ means, for a State and fiscal year, the medical assistance payments as reported by medical service category on the Form CMS-64 quarterly expense report (or successor to such a report form, and including enrollment data and subsequent adjustments to any such report, in this section referred to collectively as a ‘CMS-64 report’) that directly result from providing medical assistance under the State plan (including under a waiver of the plan) for which payment is (or may otherwise be) made pursuant to section 1903(a)(1).
“(3) EXCLUDED EXPENDITURES.—In this section, the term ‘excluded expenditures’ means, for a State and fiscal year, expenditures under the State plan (or under a waiver of such plan) that are attributable to any of the following:

“(A) DSH.—Payment adjustments made for disproportionate share hospitals under section 1923.

“(B) MEDICARE COST-SHARING.—Payments made for medicare cost-sharing (as defined in section 1905(p)(3)).

“(C) SAFETY NET PROVIDER PAYMENT ADJUSTMENTS IN NON-EXPANSION STATES.—Payment adjustments under subsection (a) of section 1923A for which payment is permitted under subsection (c) of such section.

“(4) 1903A FY 16 POPULATION PERCENTAGE.—In this subsection, the term ‘1903A FY16 population percentage’ means, for a State, the Secretary’s calculation of the percentage of the actual medical assistance expenditures, as reported by the State on the CMS–64 reports for calendar quarters in fiscal year 2016, that are attributable to 1903A enrollees (as defined in subsection (e)(1)).
“(c) TARGET TOTAL MEDICAL ASSISTANCE EXPENDITURES.—

“(1) CALCULATION.—In this section, the term ‘target total medical assistance expenditures’ means, for a State for a fiscal year, the sum of the products, for each of the 1903A enrollee categories (as defined in subsection (e)(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, State, and a fiscal year, an amount equal to—

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

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

“(d) 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 fiscal year 2016.—For each State the Secretary shall calculate (and provide notice to the State not later than April 1, 2018, of) the following:

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

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

“(C) The average per capita medical assistance expenditures for the State for fiscal year 2016 equal to—

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

“(ii) the number calculated under subparagraph (B).
“(2) Fiscal year 2019 average per capita amount based on inflating the fiscal year 2016 amount to fiscal year 2019 by CPI-Medical.—The Secretary shall calculate a fiscal year 2019 average per capita amount for each State equal to—

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

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

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

“(ii) In this paragraph, the term ‘non-DSH supplemental expenditure’ means a payment to a provider under the State plan (or under a waiver of the plan) that—

“(I) is not made under section 1923;

“(II) is not made with respect to a specific item or service for an individual;

“(III) is in addition to any payments made to the provider under the plan (or waiver) for any such item or service; and
“(IV) complies with the limits for additional payments to providers under the plan (or waiver) imposed pursuant to section 1902(a)(30)(A), including the regulations specifying upper payment limits under the State plan in part 447 of title 42, Code of Federal Regulations (or any successor regulations).

“(iii) An expenditure described in this clause is an expenditure that meets the criteria specified in subclauses (I), (II), and (III) of clause (ii) and is authorized under section 1115 for the purposes of funding a delivery system reform pool, uncompensated care pool, a designated state health 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 fiscal year 2016, the State’s non-DSH supplemental payment percentage is equal to the ratio (expressed as a percentage) of—
“(i) the total amount of non-DSH supplemental expenditures (as defined in subparagraph (A)(ii)) for the State for fiscal year 2016; to

“(ii) the amount described in subsection (b)(1)(A) for the State for fiscal year 2016.

“(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 payment percentage for the State (as calculated under subparagraph (C)); divided by

“(ii) the number calculated under subparagraph (B) for the State for the enrollee category.

“(5) Provisional FY19 per Capita Target Amount for Each 1903A Enrollee Category.—Subject to subsection (f)(2), the Secretary shall calculate for each State a provisional FY19 per capita target amount for each 1903A enrollee category equal to the average medical assistance expenditures
per capita for the State for fiscal year 2019 (as calculated under paragraph (4)(D)) for such enrollee category multiplied by the ratio of—

“(A) the product of—

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

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

“(B) the amount of the adjusted total medical assistance expenditures for the State for fiscal year 2019, as calculated under paragraph (3)(A).

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

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

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

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

“(C) Breast and Cervical Cancer Services Eligible Individual.—An individual who is entitled to medical assistance under this title only pursuant to section 1902(a)(10)(A)(ii)(XVIII).

“(D) Partial-Benefit Enrollees.—An individual who—

“(i) is an alien who is entitled to medical assistance under this title only pursuant to section 1903(v)(2);)

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

“(iii) is a dual eligible individual (as defined in section 1915(h)(2)(B)) and is entitled to medical assistance under this title (or under a waiver) only for some or
all of medicare cost-sharing (as defined in section 1905(p)(3)); or

“(iv) is entitled to medical assistance under this title and for whom the State is providing a payment or subsidy to an employer for coverage of the individual under a group health plan pursuant to section 1906 or section 1906A (or pursuant to 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 (not described in the previous subparagraph) who are eligible for medical assistance under this title on the basis of being blind or disabled.

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

“(D) EXPANSION ENROLLEES.—A category of 1903A enrollees (not described in a
previous subparagraph) for whom the amounts expended for medical assistance are subject to an increase or change in the Federal medical assistance percentage under subsection (y) or (z)(2), respectively, of section 1905.

“(E) Other nonelderly, nondisabled, non-expansion adults.—A category of 1903A enrollees who are not described in any previous subparagraph.

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

“(4) Determination of number of 1903A enrollees.—The number of 1903A enrollees for a State and fiscal year, and, if applicable, for a 1903A enrollee category, is the average monthly number of Medicaid enrollees for such State and fiscal year (and, if applicable, in such category) that are reported through the CMS–64 report under (and subject to audit under) subsection (h).

“(f) Special Payment Rules.—
“(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 approved under section 1115, section 1915, or another provision of this title, this section shall apply to medical assistance expenditures and medical assistance payments under the waiver, in the same manner as if such expenditures and payments 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 fiscal year 2016.—In the case of a State that did not provide for medical assistance for the 1903A enrollee category described in subsection (e)(2)(D) during fiscal year 2016 but which provides for such assistance for such category in a subsequent year, the provisional FY19 per capita target amount for such enrollee category under subsection (d)(5) shall be equal to the provisional FY19 per capita target amount for the 1903A enrollee category described in subsection (e)(2)(E).
“(3) In case of state failure to report necessary data.—If a State for any quarter in a fiscal year (beginning with fiscal year 2019) fails to satisfactorily submit data on expenditures and enrollees in accordance with subsection (h)(1), for such fiscal year and any succeeding fiscal year for which such data are not satisfactorily submitted—

“(A) the Secretary shall calculate and apply subsections (a) through (e) with respect to the State as if all 1903A enrollee categories for which such expenditure and enrollee data were not satisfactorily submitted were a single 1903A enrollee category; and

“(B) the growth factor otherwise applied under subsection (c)(2)(B) shall be decreased by 1 percentage point.

“(g) Recalculation of certain amounts for data errors.—The amounts and percentage calculated under paragraphs (1) and (4)(C) of subsection (d) for a State for fiscal year 2016, and the amounts of the adjusted total medical assistance expenditures calculated under subsection (b) and the number of Medicaid enrollees and 1903A enrollees determined under subsection (e)(4) for a State for fiscal year 2016, fiscal year 2019, and any subsequent fiscal year, may be adjusted by the Secretary...
based upon an appeal (filed by the State in such a form, manner, and time, and containing such information relating to data errors that support such appeal, as the Secretary specifies) that the Secretary determines to be valid, except that any adjustment by the Secretary under this subsection for a State may not result in an increase of the target total medical assistance expenditures exceeding 2 percent.

"(h) REQUIRED REPORTING AND AUDITING OF CMS–64 DATA; TRANSITIONAL INCREASE IN FEDERAL MATCHING PERCENTAGE FOR CERTAIN ADMINISTRATIVE EXPENSES.—

“(1) REPORTING.—In addition to the data required on form Group VIII on the CMS–64 report form as of January 1, 2017, in each CMS-64 report required to be submitted (for each quarter beginning on or after October 1, 2018), the State shall include data on medical assistance expenditures within such categories of services and categories of enrollees (including each 1903A enrollee category and each category of excluded individuals under subsection (e)(1)) and the numbers of enrollees within each of such enrollee categories, as the Secretary determines are necessary (including timely guidance published as soon as possible after the date of the enactment
of this section) in order to implement this section and to enable States to comply with the requirement of this paragraph on a timely basis.

“(2) AUDITING.—The Secretary shall conduct for each State an audit of the number of individuals and expenditures reported through the CMS–64 report for fiscal year 2016, fiscal year 2019, and each subsequent fiscal year, which audit may be conducted on a representative sample (as determined by the Secretary).

“(3) TEMPORARY INCREASE IN FEDERAL MATCHING PERCENTAGE TO SUPPORT IMPROVED DATA REPORTING SYSTEMS FOR FISCAL YEARS 2018 AND 2019.—For amounts expended during calendar quarters beginning on or after October 1, 2017, and before October 1, 2019—

“(A) the Federal matching percentage applied under section 1903(a)(3)(A)(i) shall be 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 in-
creased by 10 percentage points to 60 percent but only with respect to amounts expended that are attributable to a State’s additional administrative expenditures to implement the data requirements of paragraph (1).”.

Subtitle D—Patient Relief and Health Insurance Market Stability

SEC. 131. REPEAL OF COST-SHARING SUBSIDY.

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

(b) Effective Date.—The repeal made by subsection (a) shall apply to cost-sharing reductions (and payments to issuers for such reductions) for plan years beginning after December 31, 2019.

SEC. 132. PATIENT AND STATE STABILITY FUND.

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

“TITLE XXII—PATIENT AND STATE STABILITY FUND

“SEC. 2201. ESTABLISHMENT OF PROGRAM.

“There is hereby established the ‘Patient and State Stability Fund’ to be administered by the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as the ‘Administrator’), to pro-
vide funding, in accordance with this title, to the 50 States
and the District of Columbia (each referred to in this sec-
tion as a ‘State’) during the period, subject to section
2204(c), beginning on January 1, 2018, and ending on
December 31, 2026, for the purposes described in section
2202.

“SEC. 2202. USE OF FUNDS.

“A State may use the funds allocated to the State
under this title for any of the following purposes:

“(1) Helping, through the provision of financial
assistance, high-risk individuals who do not have ac-
cess to health insurance coverage offered through an
employer enroll in health insurance coverage in the
individual market in the State, as such market is de-
defined by the State (whether through the establish-
ment of a new mechanism or maintenance of an ex-
sting mechanism for such purpose).

“(2) Providing incentives to appropriate entities
to enter into arrangements with the State to help
stabilize premiums for health insurance coverage in
the individual market, as such markets are defined
by the State.

“(3) Reducing the cost for providing health in-
surance coverage in the individual market and small
group market, as such markets are defined by the
State, to individuals who have, or are projected to have, a high rate of utilization of health services (as measured by cost).

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

“(5) Promoting access to preventive services; dental care services (whether preventive or medically necessary); vision care services (whether preventive or medically necessary); prevention, treatment, or recovery support services for individuals with mental or substance use disorders; or any combination of such services.

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

“(7) Providing assistance to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled in health insurance coverage in the State.
“SEC. 2203. STATE ELIGIBILITY AND APPROVAL; DEFAULT SAFEGUARD.

“(a) Encouraging State Options for Allocations.—

“(1) In general.—To be eligible for an allocation of funds under this title for a year during the period described in section 2201 for use for one or more purposes described in section 2202, a State shall submit to the Administrator an application at such time (but, in the case of allocations for 2018, not later than 45 days after the date of the enactment of this title and, in the case of allocations for a subsequent year, not later than March 31 of the previous year) and in such form and manner as specified by the Administrator and containing—

“(A) a description of how the funds will be used for such purposes;

“(B) a certification that the State will make, from non-Federal funds, expenditures for such purposes in an amount that is not less than the State percentage required for the year under section 2204(e)(1); and

“(C) such other information as the Administrator may require.

“(2) Automatic Approval.—An application so submitted is approved unless the Administrator noti-
fies the State submitting the application, not later than 60 days after the date of the submission of such application, that the application has been denied for not being in compliance with any requirement of this title and of the reason for such denial.

“(3) ONE-TIME APPLICATION.—If an application of a State is approved for a year, with respect to a purpose described in section 2202, such application shall be treated as approved, with respect to such purpose, for each subsequent year through 2026.

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

“(b) DEFAULT FEDERAL SAFEGUARD.—

“(1) IN GENERAL.—

“(A) 2018.—For allocations made under this title for 2018, in the case of a State that does not submit an application under subsection (a) by the 45-day submission date applicable to such year under subsection (a)(1)and in the case of a State that does submit such an appli-
cation by such date that is not approved, sub-
ject to section 2204(e), the Administrator, in
consultation with the State insurance commis-
sioner, shall use the allocation that would other-
wise be provided to the State under this title
for such year, in accordance with paragraph
(2), for such State.

“(B) 2019 THROUGH 2026.—In the case of
a State that does not have in effect an approved
application under this section for 2019 or a
subsequent year beginning during the period
described in section 2201, subject to section
2204(e), the Administrator, in consultation with
the State insurance commissioner, shall use the
allocation that would otherwise be provided to
the State under this title for such year, in ac-
cordance with paragraph (2), for such State.

“(2) REQUIRED USE FOR MARKET STABILIZA-
TION PAYMENTS TO ISSUERS.—An allocation for a
State made pursuant to paragraph (1) for a year
shall be used to carry out the purpose described in
section 2202(2) in such State by providing payments
to appropriate entities described in such section with
respect to claims that exceed $50,000 (or, with re-
spect to allocations made under this title for 2020
or a subsequent year during the period specified in section 2201, such dollar amount specified by the Administrator), but do not exceed $350,000 (or, with respect to allocations made under this title for 2020 or a subsequent year during such period, such dollar amount specified by the Administrator), in an amount equal to 75 percent (or, with respect to allocations made under this title for 2020 or a subsequent year during such period, such percentage specified by the Administrator) of the amount of such claims.

**SEC. 2204. ALLOCATIONS.**

“(a) APPROPRIATION.—For the purpose of providing allocations for States (including pursuant to section 2203(b)) under this title there is appropriated, out of any money in the Treasury not otherwise appropriated—

“(1) for 2018, $15,000,000,000;
“(2) for 2019, $15,000,000,000;
“(3) for 2020, $10,000,000,000;
“(4) for 2021, $10,000,000,000;
“(5) for 2022, $10,000,000,000;
“(6) for 2023, $10,000,000,000;
“(7) for 2024, $10,000,000,000;
“(8) for 2025, $10,000,000,000; and
“(9) for 2026, $10,000,000,000.
“(b) ALLOCATIONS.—

“(1) PAYMENT.—

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

“(B) SPECIFIED DATE.—For purposes of subparagraph (A), the date specified in this clause is—

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

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

“(2) ALLOCATION AMOUNT DETERMINATIONS.—

“(A) FOR 2018 AND 2019.—

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

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

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

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

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

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

“(iii) Relative state incurred
claims proportion.—The relative State
incurred claims proportion described in
this clause for a State and year is the
amount equal to the ratio of—
“(I) the adjusted incurred claims
by the State, as reported through the
medical loss ratio annual reporting
under section 2718 of the Public
Health Service Act for the third pre-
vious year; to

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

“(iv) Relative uninsured and
issuer participation amount.—For
purposes of clause (i), the relative unin-
sured and issuer participation amount de-
scribed in this clause for a State for 2018
and 2019 is the product of—

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

“(II) the relative State uninsured
and issuer participation proportion de-
scribed in clause (v) for such State
and year.

“(v) Relative state uninsured
and issuer participation propor-
tion.—The relative State uninsured and
issuer participation proportion described in this clause for a State and year is—

“(I) in the case of a State not described in clause (vi) for such year, 0; and

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

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

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

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

“(I) The number of individuals residing in such State and described in clause (v)(II)(aa) was higher in 2015 than 2013.

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

“(B) FOR 2020 THROUGH 2026.—For purposes of paragraph (1), the amount determined under this paragraph for a year (beginning with 2020) during the period described in section 2201 for a State is an amount determined in accordance with an allocation methodology specified by the Administrator which—

“(i) takes into consideration the adjusted incurred claims of such State, the number of residents of such State who for the previous year were not enrolled in a health plan or otherwise did not have health insurance coverage (including through a Federal or State health pro-
gram) and whose income is below 100 percent of the poverty line applicable to a family of the size involved, and the number of health insurance issuers participating in the insurance market in such State for such year;

“(ii) is established after consultation with health care consumers, health insurance issuers, State insurance commissioners, and other stakeholders and after taking into consideration additional cost and risk factors that may inhibit health care consumer and health insurance issuer participation; and

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

“(c) Annual Distribution of Previous Year’s Remaining Funds.—In carrying out subsection (b), the Administrator shall, with respect to a year (beginning with 2020 and ending with 2027), not later than March 31 of such year—
“(1) determine the amount of funds, if any, from the amounts appropriated under subsection (a) for the previous year but not allocated for such previous year; and

“(2) if the Administrator determines that any funds were not so allocated for such previous year, allocate such remaining funds, in accordance with the allocation methodology specified pursuant to subsection (b)(2)(B)—

“(A) to States that have submitted an application approved under section 2203(a) for such previous year for any purpose for which such an application was approved; and

“(B) for States for which allocations were made pursuant to section 2203(b) for such previous year, to be used by the Administrator for such States, to carry out the purpose described in section 2202(2) in such States by providing payments to appropriate entities described in such section with respect to claims that exceed $1,000,000;

with, respect to a year before 2027, any remaining funds being made available for allocations to States for the subsequent year.
“(d) AVAILABILITY.—Amounts appropriated under subsection (a) for a year and allocated to States in accordance with this section shall remain available for expenditure through December 31, 2027.

“(e) CONDITIONS FOR AND LIMITATIONS ON RECEIPT OF FUNDS.—The Secretary may not make an allocation under this title for a State, with respect to a purpose described in section 2202—

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

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

“(B) for 2021, 14 percent of the amount allocated under this subsection to such State for such year and purpose;

“(C) for 2022, 21 percent of the amount allocated under this subsection to such State for such year and purpose;

“(D) for 2023, 28 percent of the amount allocated under this subsection to such State for such year and purpose;
“(E) for 2024, 35 percent of the amount allocated under this subsection to such State for such year and purpose;

“(F) for 2025, 42 percent of the amount allocated under this subsection to such State for such year and purpose; and

“(G) for 2026, 50 percent of the amount allocated under this subsection to such State for such year and purpose;

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

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

“(B) for 2021, 20 percent of the amount allocated under this subsection to such State for such year and purpose; and

“(C) for 2022, 30 percent of the amount allocated under this subsection to such State for such year and purpose;
“(D) for 2023, 40 percent of the amount allocated under this subsection to such State for such year and purpose;

“(E) for 2024, 50 percent of the amount allocated under this subsection to such State for such year and purpose;

“(F) for 2025, 50 percent of the amount allocated under this subsection to such State for such year and purpose; and

“(G) for 2026, 50 percent of the amount allocated under this subsection to such State for such year and purpose; or

“(3) if such an allocation for such purpose would not be permitted under subsection (c)(7) of section 2105 if such allocation were payment made under such section.”.

SEC. 133. CONTINUOUS HEALTH INSURANCE COVERAGE INCENTIVE.

Subpart I of part A of title XXVII of the Public Health Service Act is amended—

(1) in section 2701(a)(1)(B), by striking “such rate” and inserting “subject to section 2711, such rate”;

(2) by redesignating the second section 2709 as section 2710; and
(3) by adding at the end the following new section:

“SEC. 2711. ENCOURAGING CONTINUOUS HEALTH INSURANCE COVERAGE.

“(a) PENALTY APPLIED.—

“(1) IN GENERAL.—Notwithstanding section 2701, subject to the succeeding provisions of this section, a health insurance issuer offering health insurance coverage in the individual or small group market shall, in the case of an individual who is an applicable policyholder of such coverage with respect to an enforcement period applicable to enrollments for a plan year beginning with plan year 2019 (or, in the case of enrollments during a special enrollment period, beginning with plan year 2018), increase the monthly premium rate otherwise applicable to such individual for such coverage during each month of such period, by an amount determined under paragraph (2).

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

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

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

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

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

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

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

“(3) ENFORCEMENT PERIOD.—The term ‘en-
forcement period’ means—

“(A) with respect to enrollments during a
special enrollment period for plan year 2018,
the period beginning with the first month that
is during such plan year and that begins subse-
quent to such date of enrollment, and ending
with the last month of such plan year; and
“(B) with respect to enrollments for plan year 2019 or a subsequent plan year, the 12-month period beginning on the first day of the respective plan year.”.

SEC. 134. INCREASING COVERAGE OPTIONS.

Section 1302 of the Patient Protection and Affordable Care Act (42 U.S.C. 18022) is amended—

(1) in subsection (a)(3), by inserting “and with respect to a plan year before plan year 2020” after “subsection (e)” ; and

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

“(5) SUNSET.—The provisions of this subsection shall not apply after December 31, 2019, and after such date any reference to this subsection or level of coverage or plan described in this subsection and any requirement under law applying such a level of coverage or plan shall have no force or effect (and such a requirement shall be applied as if this section had been repealed).”.

SEC. 135. 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)), as inserted by section 1201(4) of Public Law 111–148, is amended by in-
serting after “3 to 1 for adults (consistent with section 2707(c))” the following: “or, for plan years beginning on or after January 1, 2018, as the Secretary may implement through interim final regulation, 5 to 1 for adults (consistent with section 2707(c)) or such other ratio for adults (consistent with section 2707(c)) as the State involved may provide”.