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.

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:

SEC. 1235. SYRIA STUDY GROUP.

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

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

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

(A) One member appointed by the chair of the Committee on Armed Services of the Senate, and the ranking minority member of the Committee on Armed Services of the House of Representatives.

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

(C) One member appointed by the chair of the Committee on Foreign Relations of the Senate, and the ranking minority member of the Committee on Foreign Relations of the House of Representatives.

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

(E) One member appointed by the ranking minority member 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.

(Sec. 1088. Foreign Agents Registration.)

SEC. 1088. FOREIGN AGENTS REGISTRATION.

(a) Short Title.—This section may be cited as the “Foreign Agents Registration Act of 1938 Amendment of 2017”.

(b) Civil Investigative Demand Authority.—The Foreign Agents Registration Act of 1938 (22 U.S.C. 611 et seq.) is amended—

(1) by redesignating sections 8, 9, 10, 11, 12, 13, and 14 as sections 9, 10, 11, 12, 13, 14, and 16, respectively; and

(2) by inserting a new section 8 at the end of chapter 1 of title 50, United States Code, to read as follows:

SEC. 8. Registration of agents of foreign governments and foreign political organizations.

(a) Appointment and registration of agents for prosecution before the Foreign Intelligence Surveillance Court.—The Attorney General shall, in the case of an organization that has paid a registration fee as a foreign political organization under this section, appoint an agent of the organization to serve as a liaison officer or employee of their respective organizations to serve as a liaison officer to the Group.

(b) 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:

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

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

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

(4) 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.

(5) Provide a strategy for a United States and coalition strategy to reestablish secure and governance in Syria, including recommendations for a role for stabilization, development, counterterrorism, and reconstruction efforts.

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

(7) INTERIM BRIEFING.—Not later than June 30, 2018, the Group shall provide to the Committees on Armed Forces of the House of Representatives and 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.

(8) 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.
(II) by inserting subclause (VI).

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

Beginning on page 61, strike line 15 and all that follows through page 62, line 1, and insert the following:

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

(A) for each of the 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, plus 1 percentage point; and

(B) for each of the 1903A enrollee categories described in subparagraphs (A) and (B) 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, plus 2 percentage points.

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

Beginning on page 41, strike lines 1 through 19 and insert the following:

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

(F) 88 percent for calendar quarters in 2021;

(G) 86 percent for calendar quarters in 2022;

(H) 84 percent for calendar quarters in 2023;

(I) 82 percent for calendar quarters in 2024;

(J) 80 percent for calendar quarters in 2025;

(K) 78 percent for calendar quarters in 2026;

(L) 76 percent for calendar quarters in 2027;

(M) 74 percent for calendar quarters in 2028; and

(N) 72 percent for calendar quarters in 2029.; and

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

"The Federal medical assistance percentage determined for a State and year under subsection (b) shall apply to expenditures for medical assistance to newly eligible individuals (as so described) and expansion enrollees (as so defined), in the case of a State that has elected to cover newly eligible individuals before March 1, 2017, for calendar quarters after 2028, and, in the case of any other State, for calendar quarters (or portions of calendar quarters) after February 28, 2017."

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:

"(I) by inserting subclause (VI)."
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.
Subparagraph (B) of section 36B(c)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

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

SEC. 102. PREMIUM TAX CREDIT.

(a) PREMIUM TAX CREDIT.—

(1) REPEAL.—

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

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

SEC. 103. SMALL BUSINESS TAX CREDIT.

(a) SUNSET.—

(1) IN GENERAL.—Section 501 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

“...(D) TERMINATION.—No disclosure may be made under this paragraph after December 31, 2019.’’.

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

SEC. 104. INDIVIDUAL MANDATE.

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

(1) in paragraph (2)(A)(i)(II), by striking “2.5 percent” and inserting “Zero percent”, and

(2) in paragraph (3)—

(A) by striking “895A” in subparagraph (A) and inserting “895C”;

(B) by striking subparagraph (D).

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

SEC. 105. EMPLOYER MANDATE.

(a) IN GENERAL.—

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

(2) Paragraph (1) of section 4980B(b) of the Internal Revenue Code of 1986 is amended by inserting “‘$0 in the case of months beginning after December 31, 2015’” after “$3,000’’.

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

SEC. 106. FEDERAL PAYMENTS TO STATES.

(a) IN GENERAL.—Notwithstanding section 504(a), 1002(a)(25), 1003(a), 2001, 2005(a)(4), 2005a(a)(7), or 2010 of the Social Security Act (42 U.S.C. 704(a), 1396a(a)(23), 1396a(b), 1397a, 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), for the 1-year period beginning on the date of enactment of this Act, no Federal funds provided from a program referred to in this subsection that is considered direct spending for any year may be made available to a State for payments to a prohibited entity, whether made directly to the prohibited entity or through a managed care organization under contract.

(b) DEFINITIONS.—In this section:

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

(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 220(d)(2) of the Internal Revenue Code of 1986; or

(iii) is a State, or a political subdivision of a State, as well as an automobile carrier, a boat, a vessel, or a plane;

(B) in subsection (z)(2)—

(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 220(d)(2) of the Internal Revenue Code of 1986; or

(iii) is a State, or a political subdivision of a State, as well as an automobile carrier, a boat, a vessel, or a plane;

(2) EFFECTIVE DATE.—The repeal in paragraphs (1) and (2) and before January 1, 2020’’.

SEC. 112. REPEAL OF LIMITATIONS ON CONSIDERATION OF MATERNITY MEDICATIONS.

(a) IN GENERAL.—Section 223(f)(2) of the Internal Revenue Code of 1986 is amended by striking “Such term” and all that follows through “thereafter”; and

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

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

SEC. 113. 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 “thereafter”;

(b) ARCHIE 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 “thereafter”;

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts paid with respect to taxable years beginning after December 31, 2025.

(d) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts paid with respect to taxable years beginning after December 31, 2025.

(e) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts paid with respect to taxable years beginning after December 31, 2025.

SEC. 114. REPEAL OF TAX ON HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “20 percent” and inserting “15 percent”; and

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

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

SEC. 115. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO FLEXIBLE SPENDING ACCOUNTS.

(a) HSA S.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “20 percent” and inserting “15 percent”;

(b) ARCHIE 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 contributions made 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 apply to calendar years beginning after December 31, 2010, and ending before January 1, 2018."

SEC. 114. REPEAL OF MEDICAL DEVICE EXCISE TAX.
Section 4911 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"", and at the end of paragraph (1) and all that follows through ""2017."

SEC. 116. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO IRAs.

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

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

SEC. 117. REPEAL OF MEDICARE TAX INCREASE.

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

"(b) E FFECTIVE 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.—Subtitle (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 any individual a tax equal to 1.45 percent of the wages (as defined in section 3121(a)) received during 2019 as compensation for services performed after December 31, 2018, by a hospital 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 the self-employment income for such taxable year.

(c) E FFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received after, and taxable years beginning after, December 31, 2018.

SEC. 119. REPEAL OF TANNING TAX.

(a) IN GENERAL.—Subsection (b) of section 402 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u-11) is amended—

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

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

(b) E FFECTIVE DATE.—The amendment 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 268, Mr. WHITEHOUSE 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. _. MEDICAL BANKRUPTCY FAIRNESS.

(a) DEFINITIONS.—

(1) IN GENERAL.—Section 101 of title 11, United States Code, is amended—

(A) by inserting after paragraph (39A) the following:

"(r)(1) If a medically distressed debtor incurred or paid aggregate medical debts for the debtor, a dependent of the debtor, or, a nondependent parent, grandparent, sibling, child, grandchild, or spouse of the debtor that were not paid by any third-party payor and were greater than the lesser of—

(I) 10 percent of the debtor's adjusted gross income (as such term is defined in section 62 of the Internal Revenue Code of 1986); or

(II) $10,000;

(ii) did not receive domestic support obligations, or had a spouse or dependent who did not receive domestic support obligations, of at least $10,000 due to a medical issue of the person obligated to pay that would cause the obligor to not meet the requirements under clause (i) or (ii), if the obligor was a debtor in a case under this title; or

(iii) experienced a change in employment status that resulted in a reduction in wages, salaries, commissions, or work hours or resulted in unemployment due to—

(I) an injury, deformity, or disease of the debtor; or

(II) care for an injured, deformed, or ill dependent or nondependent parent, grandparent, sibling, child, grandchild, or spouse of the debtor; or

(B) a debtor who is the spouse of a debtor described in subparagraph (A).

(2) CONFORMING AMENDMENTS.—Section 101 of title 11, United States Code, is amended—

(A) in subsection (a), in the matter preceding paragraph (1), by inserting "101(39C)(A)," after "101(19)(A),"; and

(B) in subsection (b), by inserting "101(39C)(A)," after "101(19)(A)."

(b) EXEMPTIONS.—

(1) EXEMPT PROPERTY.—Section 522 of title 11, United States Code, is amended by adding at the end the following:

"(v) If a medically distressed debtor is unlawfully incarcerated in a public property like a prison, the debtor may, in lieu of the exemption provided under subsection (d)(1), elect to exempt

"
the debtor’s aggregate interest, not to exceed $250,000 in value, in property described in paragraph (3) of this subsection.

(2) If a medically distressed debtor exempt property listed in subsection (b)(3) and the exemption provided under applicable law specifically for the kind of property described in paragraph (3) is for less than $250,000, the debtor may exempt property used as a residence or owned by a dependent of the debtor.

(3) The property described in this paragraph is—

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

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

(C) 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 “522(r),” after “522(q),”;

(B) in subsection (b), by inserting “522(r),” after “522(q),”;

(C) by waiving of Administrative Requirements.—

(A) 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) does not apply in any case in which the debtor is a medically distressed debtor.

(B) CASE UNDER CHAPTER 13.—Section 1325(b)(1) of title 11, United States Code, is amended by inserting “a medically distressed debtor or” after “apply with respect to”.

(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 grants for the establishment of Department of Defense laboratories and such researchers.

(b) Modification of Program Activities.—Subsection (c) of such section is amended—

(1) by redesignating 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 grants for the establishment of Department of Defense laboratories and such researchers.

(c) Modification of Eligibility Criteria for State Participation.—Subsection (d) of such section is amended—

(1) by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively;

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

(3) The Under Secretary shall not remove a description from 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.

(2) Clerical Amendment.—Such Act is amended, in the table of contents in section 257 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103–337; 10 U.S.C. 2308 note) is amended—

(a) Model Appropriations 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;

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

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

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

(c) Modification of Program Activities.—Subsection (c) of such section is amended—

(1) by redesignating 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 grants for the establishment of Department of Defense laboratories and such researchers.

(d) Modification of Eligibility Criteria for State Participation.—Subsection (d) of such section is amended—

(1) by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively;

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

(3) The Under Secretary shall not remove a description from 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.

(Sec. 101. Elimination of Limitation on Reprise of Premium Tax Credits.)

Subparagraph (b) of section 36B(e)(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.”

Title II. 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 350 percent”, and

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

(2) treatment of credits.—

(A) in general.—Section 36B(e)(2) 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 “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” and striking “or a qualified alien (within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996)”.

(iii) Section 1411(b)(2) of such Act is amended 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)”.

(2) by striking “individuals not lawfully present in the United States” and inserting “individuals not lawfully present in the United States”.

(iv) the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(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 (2)(C)(i) and inserting “applicable median cost benchmark plan”;

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

(iii) in paragraph (3)(B) 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 (2)(C)(i) and inserting “applicable median cost benchmark plan”;

(ii) by striking “such silver plan” in paragraph (2)(C)(i) and inserting “such benchmark plan”;
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 at least the floor of the individual market in such rating area (or, in any case in which no such plan has such mean premium, has a premium nearest (but not in excess of) such median premium),”.

and

“(ii) by striking “clause (ii)(I)” in the flush text at the end 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 paragraph (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 described in such clause.”.

(2) MODIFICATION OF APPLICABLE PERCENT-AGE.—Section 36B(b)(4)(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 inserted in paragraph (i), and

(B) by striking the following:

<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>
<td>Final</td>
</tr>
<tr>
<td>100%-133%</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>131%-150%</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>150%-200%</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>200%-250%</td>
<td>5.3</td>
<td>5.3</td>
<td>5.9</td>
<td>6.3</td>
<td>8.05</td>
</tr>
<tr>
<td>250%-300%</td>
<td>6.4</td>
<td>6.4</td>
<td>5.9</td>
<td>8.05</td>
<td>8.35</td>
</tr>
<tr>
<td>300%-350%</td>
<td>6.4</td>
<td>6.4</td>
<td>5.9</td>
<td>8.05</td>
<td>8.35</td>
</tr>
</tbody>
</table>

(B) by striking “.504” in clause (ii)(III) and inserting “.4”, and

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

“(iii) ADMISSIONS.—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) ELIMINATION 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), (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.

(g) EFFECTIVE DATE.—Except as otherwise provided in this section, the amendments made by this section shall apply to taxable years beginning after December 31, 2019.

SEC. 103. MODIFICATIONS TO SMALL BUSINESS TAX CREDIT.

(a) SUNSET.—

(1) IN GENERAL.—Section 4980H(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

“(d) SECURITIES AND EXCHANGE DISRUPTION AND RESPONSE FUND.—

(1) IN GENERAL.—Section 2105 of the Securities Act (42 U.S.C. 1397ee) is amended by adding at the end the following new subsection:

“(h) APPROPRIATION.—There are authorized to be appropriated, and are appropriated, out of monies in the Treasury not otherwise obligated, $5,000,000,000 for each of the fiscal years 2018 and 2019, and $10,000,000,000 for each of the fiscal years 2020 and 2021, to the Administrator of the Centers for Medicare & Medicaid Services (in this paragraph and subsection (i) 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.—

“(b) LONG-TERM ASSISTANCE TO ADDRESS COVERAGE AND ACCESS DISRUPTION AND PROVIDE SUPPORT FOR STATES.—

“(1) APPROPRIATION.—There is appropriated to the Secretary of Health and Human Services $5,000,000,000 for each of the fiscal years 2018 and 2019, and $10,000,000,000 for each of the fiscal years 2020 and 2021, to the Administrator of the Centers for Medicare & Medicaid Services (in this subsection and subsection (i) 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.—

“(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.

SEC. 104. INDIVIDUAL MANDATE.

(a) IN GENERAL.—Section 4980H(c) of the Internal Revenue Code of 1986 is amended by inserting “(5) in the case of months beginning after December 31, 2015)” after “(5) in the case of months beginning after December 31, 2013)”.2

(2) Paragraph (1) of section 4980H(b) of the Internal Revenue Code of 1986 is amended by inserting “(5) in the case of months beginning after December 31, 2015)” after “(5) in the case of months beginning after December 31, 2013)”.2

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

SEC. 105. EMPLOYER MANDATE.

(a) IN GENERAL.—

(1) Paragraph (1) of section 4980H(c) of the Internal Revenue Code of 1986 is amended by inserting “(5) in the case of months beginning after December 31, 2015)” after “(5) in the case of months beginning after December 31, 2015)”.2

(2) Paragraph (1) of section 4980H(b) of the Internal Revenue Code of 1986 is amended—

(A) in clause (i), by striking “from the initial premium percentage” and all that follows inserted in paragraph (i), and

(B) by striking the following:

<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>
<td>Final</td>
</tr>
<tr>
<td>100%-133%</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>131%-150%</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>150%-200%</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>200%-250%</td>
<td>5.9</td>
<td>5.9</td>
<td>5.9</td>
<td>8.05</td>
<td>8.35</td>
</tr>
<tr>
<td>250%-300%</td>
<td>6.4</td>
<td>6.4</td>
<td>5.9</td>
<td>8.05</td>
<td>8.35</td>
</tr>
<tr>
<td>300%-350%</td>
<td>6.4</td>
<td>6.4</td>
<td>5.9</td>
<td>8.05</td>
<td>8.35</td>
</tr>
</tbody>
</table>

(B) by striking paragraph (2)(B)(i)(I)(II), by striking “2.5 percent” and inserting “Zero percent”, and

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

SEC. 106. STATE STABILITY AND INNOVATION FUND.
‘(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 amount for providing funds under this subsection that includes an amount equal to 1 percent of the amounts appropriated under paragraph (1) for each fiscal year for providing and distributing funds to health insurance issuers in States where the cost of insurance premiums are at least 75 percent higher than the national average.

‘(4) No MATCH.—Neither the State percentage applicable to payments to States under subsection (a)(3) nor any other matching requirement shall apply to funds provided to health insurance issuers under this subsection.

‘(5) USE OF FUNDS.—Funds provided to a health insurance issuer under paragraph (1) or (6) shall be subject to the requirements of paragraphs (1)(D) and (7) of subsection (i) in the State that meet the conditions in such subparagraphs, or shall be treated as only referring to a State receiving payments under subsection (i) and shall be used only for the activities specified in paragraph (1)(A) of subsection (i).

‘(6) 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 appropriated, $10,000,000,000 for each of calendar years 2020 through 2026, for the purpose of funding arrangements with health insurance issuers to support 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) Use of Funds.—

(i) IN GENERAL.—The Administrator shall use amounts appropriated under subparagraph (A) to establish a Federal fund for the purpose of providing health insurance coverage by making payments to health insurance issuers that offer a plan in accordance with section 212(a) of such Act. The Administrator shall determine an appropriate amount for providing funds under this subsection that includes an amount equal to the Federal percentage for such a year, and the State percentage is equal to the Federal percentage reduced by the State percentage for such a year, and the State percentage is equal to

(ii) PRIORITY USES.—In making payments from the amounts appropriated under subparagraph (A), the Administrator shall prioritize the payments—

(I) based on the percentage of rate increases in the State that meet the conditions in section 212(b) of such Act; and

(II) to health plans certified under section 212(b)(2) of such Act for which paragraphs (1) through (6) of section 212(c) of such Act are not applicable.

‘(7) LONG-TERM STATE STABILITY AND INNOVATION PROGRAM.—

‘(1) APPLICATION AND CERTIFICATION REQUIREMENTS.—To be eligible for an allotment, under this subsection, a State shall submit to the Administrator an application, not later than March 31, 2018, in the case of allotments for calendar year 2019, and not later than March 31 of the previous year, in the case of allotments for any subsequent calendar year, and in such form and manner as specified by the Administrator, that contains—

(A) A description of how the funds will be used to do 1 or more of the following:

(i) To establish or maintain a program or mechanism to help high-risk individuals in the purchase of health benefits coverage, including by reducing premium costs for such individuals who are projected to have a high rate of utilization of health services, as measured by cost, and who do not have access to health insurance coverage of comparable quality and cost for a calendar year for allotments under this subsection.

(ii) To establish or maintain a program to enter into arrangements with health insurance issuers to assist in the purchase of health benefits coverage by stabilizing premiums and promoting State health insurance market participation and choice in plans certified under section 212(a) of the Internal Revenue Code of 1986.

(iii) To provide payments for health care providers for the provision of health care services, as specified by the Administrator.

(iv) To provide health insurance coverage by funding assistance to reduce out-of-pocket costs, such as copayments, coinsurance, deductibles, of individuals enrolled in plans offered in the individual market (within the meaning of section 5000A(f)(1)(C) of the Internal Revenue Code of 1986).

(v) To provide payments to States for a calendar 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 fiscal year under subparagraph (A), such amount as specified by the Administrator with respect to the State and application approved under subparagraph (A) in the case of calendar year 2021.

(vi) To establish or maintain a program or mechanism to help high-risk individuals in the purchase of health benefits coverage, in the case of calendar year 2021, the Administrator shall, not later than March 31 of such year, determine the amount of funds, if any, remaining unused under subparagraph (A) from the previous year; and

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

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

(C) A certification that none of the funds provided under this subsection shall be used by 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 this title and title XIX or under a waiver of such plans.

(E) Such other information as necessary for the Administrator to carry out this subsection.

(2) ELIGIBILITY.—Only the 50 States and the District of Columbia shall be eligible for an allotment under this subsection. A State shall be treated as only referring to the 50 States and the District of Columbia.

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

(4) LONG-TERM STATE STABILITY AND INNOVATION ALLOTMENTS.—

(A) APPROPRIATION; TOTAL ALLOTMENT.—For the purpose of providing allotments to States under this subsection, there is appropriated, out of any money in the Treasury,

(i) in the case of calendar year 2019, $8,000,000,000;

(ii) in calendar year 2020, $29,000,000,000;

(iii) in calendar year 2021, $29,000,000,000;

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

(v) for calendar year 2023, $33,200,000,000;

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

(vii) for calendar year 2025, $33,200,000,000; and

(viii) for calendar year 2026, $33,200,000,000.

(B) ALLOCATION OF FUNDS.—

(i) IN GENERAL.—In the case of a State with an application approved under this subsection with respect to a year, the Administrator shall allot to the State, in accordance with an allotment methodology specified by the Administrator that ensures that the allotment is not less than the State percentage for each State where the cost of insurance premiums are at least 75 percent higher than the national average, from amounts appropriated for each fiscal year under subparagraph (A), such amount as specified by the Administrator with respect to the State and application approved under subparagraph (A) in the case of calendar year 2021.

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

(I) IN GENERAL.—In carrying out clause (i), if the Administrator determines that a State has a year during which the allotment methodology of the Administrator is not met for the year and that reserves an amount that is at least 1 percent of the amount appropriated under subparagraph (A) for such fiscal year, the Administrator shall, not later than March 31 of such year, redistribute the amount of funds remaining under subparagraph (A) in the case of calendar year 2021, the Administrator shall not later than March 31 of such year, determine the amount of funds, if any, remaining unused under subparagraph (A) from the previous year; and

(ii) if the Administrator determines that any 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.

(iii) APPLICABLE STATE PERCENTAGE.—The State percentage specified for a year in paragraph (5)(B)(ii) shall apply to funds redistributed under subparagraph (A)(i).

(C) AVAILABILITY OF ALLOTTED STATE FUNDS.—

(i) IN GENERAL.—Amounts allotted to a State pursuant to subparagraph (B)(i) for a year shall remain available for expenditure by the State through the end of the second succeeding calendar year.

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

(iv) STATE EXPENDITURES REQUIRED BEGINNING 2022.—For purposes of subparagraph (A), the Federal percentage reduced by the State percentage for that year, and the State percentage is equal to

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

(v) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—

(I) IN GENERAL.—If the Administrator deems it appropriate, the Administrator shall make payments under this subsection for each year on the basis of advance estimates of expenditures submitted by the
(b) FUNDING.—There is appropriated to the Fund, out of any funds in the Treasury not otherwise appropriated, $500,000,000.

SEC. 106. REPEAL OF THE TAX ON EMPLOYER HEALTH PLAN CONTRIBUTIONS FOR PREMIUMS AND HEALTH PLAN BENEFITS. (a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by striking sections 223(d)(2) and 223(f)(4)(A). (b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to plan years beginning after December 31, 2016.

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. 110. REPEAL OF TAX ON HEALTH SAVINGS ACCOUNTS. (a) HSAS.—Subparagraph (A) of section 223(d)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “20 percent” and inserting “10 percent”. (b) ARCHER MSAS.—Subparagraph (A) of section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “20 percent” and inserting “15 percent”. (c) EFFECTIVE DATE.—The amendments made by title V shall apply to taxable years beginning after December 31, 2016.

SEC. 111. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO FLEXIBLE SPENDING ACCOUNTS. (a) IN GENERAL.—Paragraph (2) of section 125 of the Internal Revenue Code of 1986 is amended by— (1) striking “20 percent” and inserting “10 percent”;

(b) ARCHER MSAS.—Subparagraph (A) of section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “20 percent” and inserting “15 percent”.

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

SEC. 112. REPEAL OF TAX ON PRESCRIPTION ACCOUNTS. (a) IN GENERAL.—Section 4191 of the Internal Revenue Code of 1986 is amended by— (1) striking “20 percent” and inserting “10 percent”;

(b) ARCHER MSAS.—Section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “20 percent” and inserting “15 percent”.

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

SEC. 114. REPEAL OF HEALTH INSURANCE PREMIUMS AND HEALTH REIMBURSEMENT ARRANGEMENTS. (a) IN GENERAL.—Section 106 of the Internal Revenue Code of 1986 is amended to read as follows:

‘‘(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)(ii) 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.

(‘‘(B) ASSISTANCE WITH OUT-OF-POCKET COSTS.—In determining allotments for States under this subsection for each of calendar years 2020 through 2024, the Administrator shall ensure that at least $15,000,000,000 of the amounts appropriated for each calendar year 2020 and 2021 under paragraph (4)(A) are used by States for the purposes described in paragraph (1)(A)(ii) 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 amounts paid under this subsection.’’. (b) EFFECTIVE DATE.—The amendment made by this section shall apply to plan years beginning after December 31, 2016.

SEC. 115. REPEAL OF ELIMINATION OF DEDUCTION FOR EMPLOYER HEALTH INSURANCE PREMIUMS OR 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 paragraph—

“(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 section 219.

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

SEC. 118. PURCHASE OF INSURANCE FROM HEALTH SAVINGS ACCOUNTS. (a) PURCHASE OF HIGH DEDUCTIBLE HEALTH PLANS. (1) IN GENERAL.—Paragraph (2) of section 223(d) of the Internal Revenue Code of 1986, as amended by section 108(a), is amended— (A) by striking “and any dependent” (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof of such individual) in subparagraph (A) of subsection (b)(2) and, except in the case of funds made available under subsection (h) or the Long-Term State Stability and Innovation Program established in section 102, there is provided for purposes of carrying out section 223(d)(2) of the Internal Revenue Code of 1986, and excluding amounts made available under subsection (i) and, except in the case of funds made available under subsection (b)(2), there is provided for purposes of carrying out any other provision of law, a reimbursement arrangement under subsection (b)(2) of the Internal Revenue Code of 1986, and, except in the case of funds made available under subsection (i), there is provided for purposes of carrying out any other provision of law, a reimbursement arrangement under section 102 of the Internal Revenue Code of 1986 is amended by striking subsection (f).

(b) ARCHER MSAS.—Subparagraph (A) of section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “20 percent” and inserting “15 percent”.

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

SEC. 119. REPEAL OF THE TAX ON OVER-THE-COUNTER MEDICATIONS. (a) IN GENERAL.—Paragraph (2) of section 109(a), as amended by section 109(a), is amended— (A) by striking “and any dependent” (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof of such individual, and any child (as defined in section 152(f)(1)) of such individual who has not attained the age of 27 before the end of such individual’s taxable year”;

(b) by striking subparagraph (B) and inserting the following:

“(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Except as provided in subparagraph (C), subparagraph (A) shall not apply to any payment for insurance.”;

and

(C) by striking “or” at the end of subparagraph (C)(ii), by striking the period at the end of subparagraph (C)(ii) and inserting “and”, and by adding at the end the following:

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

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

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

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

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

(b) CONSUMER FREEDOM PLANS.— (1) IN GENERAL.—Section 222 of the Internal Revenue Code of 1986 is amended by—

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

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

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

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

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

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

(b) CONSUMER FREEDOM PLANS.— (1) IN GENERAL.—Section 222 of the Internal Revenue Code of 1986 is amended by—

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

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

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

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

(“III) any amount excludable from gross income with respect to such coverage under section 106 (including by reason of section 125 or 402(c)).”.
SEC. 119. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAVINGS ACCOUNT INCREASED TO AMOUNT OF DEDUCTIBLE AND OUT-OF-POCKET LIMITATION.

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

(c) COST-OF-LIVING ADJUSTMENT.—Section 223(b)(2)(C) of such Code is amended—

(1) by striking subsections (b)(2) and both places it appears and inserting "section", and

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

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

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

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

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

"(A) IN GENERAL.—In the case of individuals who are married to each other, if both spouses are eligible individuals and 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) 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 limitation between the spouses referred to in subparagraph (A)(iii).

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

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

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

"(D) TREATMENT OF CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.—If a health savings account is established during the 60-day period beginning on the date that coverage of the account beneficiary under a high deductible health plan begins, then, solely for purposes of determining whether a plan is treated as having been established on the date the coverage begins.

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

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

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

"A high deductible health plan shall not be treated as described in clause (v) if such plan 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 amendment made by this section shall apply with respect to coverage under a high deductible health plan beginning after December 31, 2017.

SEC. 123. FEDERAL PAYMENTS TO STATES.

(a) IN GENERAL.—Section 223(c)(2) of the Internal Revenue Code of 1986 is amended by inserting "the amount in effect under" and all that follows through "account".

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

SEC. 124. MEDICAID PROVISIONS.

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

(1) in section 1902(a)(17)(B)(ii), by striking "and before January 1, 2020''; and

(2) in section 1902(k)(2) (42 U.S.C. 1396k(k)(2)), by striking "or after the date referred to in paragraph (1) and before January 1, 2020''; and

(b) EFFECTIVE DATE.—The term "direct spending" has the meaning given that term under section 250(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900(c)).

SEC. 125. MEDICAID EXPANSION.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(1) in section 1902 (42 U.S.C. 1396a) —

(A) in subsection (a)(10) —

(i) in clause (i)(VIII), by inserting "and that has elected to cover"

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

(B) for which the total amount of Federal and State expenditures under the Medicaid expansion title 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 Emergency Deficit Control Act of 1985 (2 U.S.C. 900(c)).
described in subclause (VIII) of section 1902(a)(10)(A)(i), and, with respect to amounts expended by such State after December 31, 2019, and before January 1, 2024, for medical assistance for expansion enrollees (as defined in section 1902(nn)(1)), shall be equal to the higher of the percentage otherwise determined for the State and year under subsection (b) (without regard to this subsection) and;  
(ii) in subparagraph (D), by striking “and” after the semicolon; and  
(iii) by striking subparagraph (E) and inserting the following new subparagraphs:  
(E) 90 percent for calendar quarters in 2020;  
(F) 85 percent for calendar quarters in 2021;  
(G) 80 percent for calendar quarters in 2022; 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 flush sentence:  
“The Federal medical assistance percentage determined for a State and year under sub- 
section (b) for expenditures for medical assistance to newly eligible individ- 
uals (as so described) and expansion enrollees (as so defined), in the case of a State that has 
been identified by the Secretary under paragraph (1) as a non-expansion State for fiscal years 
beginning on or after the first day of the first month for which the State no longer 
meets the definition of a non-expansion State for purposes of subsection (a), shall be determined as if there had been no increase in the State’s DSH allotment for fiscal year 2020 under clause (ii)(I).”.

SEC. 126. RESTORING FAIRNESS IN DSH ALLOW- 
MENTS.

Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396u- 
7(b)(5)) is amended by adding after the following new subclause:  
“(I) For each State, the Secretary shall 
determine as if the State’s DSH allotment for each of fiscal years 2021 through 2023 and the fiscal years thereafter shall be determined as if there had been no increase in the State’s DSH allotment for fiscal year 2020 under clause (ii)(I).”.

SEC. 127. REDUCING STATE MEDICAID COSTS.

(a) IN GENERAL.—Section 1902(a)(34) of the Social Security Act (42 U.S.C. 1396a(a)(34)) is amended by inserting after section 1923 (42 U.S.C. 1396r–4) the following new section:

“COVERAGE EXPANSION.—If a State is a non-expansion State for fiscal year 2020 had been increased under clause (ii)(I).”.

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

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

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

This section shall not apply to those provisions of the Social Security Act (42 U.S.C. 1396–4) that provide for payments to safety net providers that are not in effect on the date of enactment of this Act.”.

SEC. 129. ANNUAL ALLOTMENT LIMITATION.

(a) IN GENERAL.—Section 1902(a)(39) of the Social Security Act (42 U.S.C. 1396a(a)(39)) is amended by inserting before the period at the end the following new clause:  
“(I) A State shall not be treated as having an annual allotment for any fiscal year under this section in excess of the product of $2,000,000,000 multiplied by the ratio of—  
the population of the State with income below 138 percent of the poverty line in 2015 (as determined based the table entitled ‘Federal Poverty Level’ in the Code of Federal Regulations, Part 3500, and the most recent information available from the Bureau of the Census).  
the United States Department of Health and Human Services’ estimate of the number of individuals who are uninsured in the State for the fiscal year under consideration (as determined based the table entitled ‘Health Insurance Coverage Status and Type of the Civilian Noninstitutionalized Population’ in the 2015 American Community Survey 1-Year Estimates, as published by the Bureau of the Census), by 12.”
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. 130. Optional Work Requirement for Nondisabled, Nonelderly, Nonpregnant Individuals.

(a) In General.—Section 1902(e)(14) of the Social Security Act (42 U.S.C. 1396a(e)(14)) (relating to modified adjusted gross income) is amended by adding at the end the following:

"(1) Frequency of Eligibility Redeterminations.—Beginning on October 1, 2017, and notwithstanding subparagraph (d), 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 percentage otherwise applicable under section 1903(a)(1) of the Social Security Act (42 U.S.C. 1396b(a)) with respect to State expenditures attributable to activities carried out by the State during such calendar quarter that are attributable to meeting the requirement of section 1902(e)(14) (relating to determinations of eligibility using modified adjusted gross income) 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)(4)) to increase the frequency of eligibility redeterminations.

SEC. 131. Provider Taxes.

Section 1902(w)(4)(C) of the Social Security Act (42 U.S.C. 1396b(w)(4)(C)) is amended by adding at the end the following new clause:

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

"(1) for fiscal year 2021, '5.8 percent' shall be substituted for '6 percent' each place it appears;

"(2) for fiscal year 2022, '5.6 percent' shall be substituted for '6 percent' each place it appears;

"(III) for fiscal year 2023, '5.4 percent' shall be substituted for '6 percent' each place it appears;

"(IV) for fiscal year 2024, '5.2 percent' shall be substituted for '6 percent' each place it appears;

"(V) for fiscal year 2025 and each subsequent fiscal year, '5 percent' shall be substituted for '6 percent' each place it appears;".

"(2) the Federal average medical assistance matching percentage under this subsection (as defined in paragraph (3)) for the State for the fiscal year; and

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

"(iv) 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 paragraph (1) did not apply; to

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

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 section 1903A(a)" as otherwise provided in this section"; and

"(1) in subsection (d)(1), by striking "to which, subject to amounts for per capita base periods selected under this subsection." and inserting "to which, subject to amounts for per capita base periods selected under this subsection."

"(2) Required Exceptions.—States administering a work requirement under this subsection may establish such exceptions as the Secretary shall approve.

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

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

"(C) an individual who is the only parent or caretaker the family of a child with disabilities, who has not attained 6 years of age or who is the only parent or caretaker of a child with disabilities; or

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

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

"(2) participates in education directly related to employment."

"(b) Increased Matching Rates.—In this subsection, the term 'excess aggregate medical assistance expenditures' means, for a State for a fiscal year, the product of—

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

"(B) the Federal average medical assistance matching percentage under this subsection (as defined in paragraph (3)) for the State for the fiscal year; and

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

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

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

"(d) Per Capita Base Period.—

"(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 base period, or to diminish the amount of the data from the per capita base period used to make determinations under this section, the Secretary may adjust the data as he deems appropriate.

"(b) ADJUSTED TOTAL MEDICAL ASSISTANCE EXPENDITURES.—Subject to subsection (g), the formula for determining (as defined in paragraph (5)) for the State and period, reduced by the amount of any excluded expenditures (as defined in paragraph (3)) for a State and fiscal year otherwise included in such medical assistance expenditures; and

"(ii) the 1903A base period 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 the State’s per capita base period, that are attributable to 1903A enrollees (as defined in subsection (e)(1)).

"(C) AGGREGATE LIMITATION ON EXCLUSIONS AND ADDITIONS TO 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 described in subparagraph (B).

"(D) DECREASE IN TARGET EXPENDITURES FOR REQUIRED EXPENDITURES BY CERTAIN POLITICAL SUBDIVISIONS.—In the case of a State that has 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 Secretary for such fiscal year, other than contributions described in subparagraph (B)."
“(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.

“(A) IN GENERAL.—Beginning with fiscal year 2020, the target per capita medical assistance expenditures for a 1903A enrollee category, for fiscal year 2019 as determined under paragraph (2), shall be adjusted (subject to subparagraph (C)(ii)) in accordance with this paragraph.

“(B) The number of 1903A enrollees for the State, category, and fiscal year, as determined under paragraph (3)(B); to

“(ii) the number calculated under subparagraph (A);

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

“(2) FISCAL YEAR 2019 AVERAGE PER CAPITA BASE PERIOD AMOUNT FOR 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 the State’s per capita base period (as calculated under paragraph (E)) for the period; divided by

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

“(3) AVERAGE PER CAPITA MEDICAL ASSISTANCE EXPENDITURES.—For purposes of this paragraph, the term ‘average per capita medical assistance expenditures’ means the average medical assistance expenditures per State for fiscal year 2019, as determined by the Secretary, divided by the number calculated under subparagraph (A).

“(4) PER CAPITA EXPENDITURES FOR FISCAL YEAR 2019 FOR EACH 1903A ENROLLEECATEGORY.—The Secretary shall calculate for each State the following:

“(A) The amount of the adjusted total medical assistance expenditures (as defined in subparagraph (2)); to

“(B) The number of 1903A enrollees for the State for the period; divided by

“(C) The average per capita medical assistance expenditures for the State for the period; divided by

“(D) The number of 1903A enrollees for the State for the period.

“(E) The amount of the adjusted total medical assistance expenditures (as defined in subparagraph (2)); to

“(F) The number of 1903A enrollees for the State for the period; divided by

“(G) The average per capita medical assistance expenditures for the State for the period; divided by

“(H) The number of 1903A enrollees for the State for the period.

“(5) PROVISIONAL FY19 PER CAPITA TARGET AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—Subject to subsection (g), the following shall apply:

“(1) CALCULATION OF BASE AMOUNTS FOR PER CAPITA BASE PERIOD AMOUNT FOR FISCAL YEAR 2019 BY CPI-MEDICAL.—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; divided by

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

“(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 State equal to—

“(A) the average per capita medical assistance expenditures for the State for the State’s per capita base period (as calculated under paragraph (E)) for the period; 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 12-month period ending with the last month 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 subparagraph (2)) for the State for fiscal year 2019; divided by

“(B) The number of 1903A enrollees for the State for fiscal year 2019 (as determined under subsection (e)(4)).

“(C) The aggregate and average expenditures per capita for each State for fiscal year 2019, as calculated under paragraph (C); divided by

“(D) The number of 1903A enrollees for the State for fiscal year 2019.

“(E) The amount of the adjusted total medical assistance expenditures (as defined in subparagraph (2)) for the State for fiscal year 2019; divided by

“(F) The number of 1903A enrollees for the State for fiscal year 2019.

“(G) The aggregate and average expenditures per capita for each State for fiscal year 2019, as calculated under paragraph (C); divided by

“(H) The number of 1903A enrollees for the State for fiscal year 2019.
(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 (4)(A)(iii)) who is eligible for medical assistance for any expenditure exceeding 2 percent. (ii) is eligible for medical assistance under this title for the month.

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

(A) ELDERLY.—A category of 1903A enrollees (not described in a previous subparagraph) who—

(i) are enrolled in a State plan under this title for the month.

(ii) are eligible for medical assistance under this title for the month.

(B) BLIND AND DISABLED CHILDREN.—An individual who—

(i) is enrolled in a State plan under this title for the month.

(ii) is eligible for medical assistance under this title for the month.

(C) CHILDREN.—A category of 1903A enrollees (not described in a previous subparagraph) who—

(i) are enrolled in a State plan under this title for the month.

(ii) are eligible for medical assistance under this title for the month.

(D) EXPANSION ENROLLEES.—A category of 1903A enrollees (not described in a previous subparagraph) who—

(i) are enrolled in a State plan under this title for the month.

(ii) are eligible for medical assistance under this title for the month.

(E) MEDicaid ENROLLEES.—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 title XIX of such title for the month.

(F) 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 the State under title XIX (or, if applicable, in such category) that are reported through the CMS–64 report under (subject to audit under subsection (h)).

1. APPLICATION IN CASE OF RESEARCH AND DEMONSTRATION PROJECTS AND OTHER WAYS.—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 under the terms determined by the Secretary in a 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 JULY 1, 2016.—In the case of a State that did not provide for medical assistance under subsection (c)(2)(B) of section 1905(b) of title 19 of the United States Code and provided for coverage and medical assistance for such expenditures under a State plan approved under section 1115, the Secretary shall ensure that such coverage and medical assistance under such State plan are included in the number of 1903A enrollees as if those expenditures and payments had been made under a State plan under this title and the limitations on such 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.

3. IN CASE OF STATE FAILURE TO REPORT NEEDED DATA FOR ANY QUARTER IN A FISCAL YEAR (BEGINNING WITH FISCAL YEAR 2019) FAILS TO SATISFACTORY SUBMIT DATA ON EXPENDITURES AND ENROLLEES IN ACCORDANCE WITH SUBPARAGRAPHS (I) AND (II) OF SUBSECTION (a)(3) OF SUCH TITLE, THE SECRETARY SHALL CONDUCT A STATISTICAL AUDIT OF SUCH EXPENDITURES AND ENROLLEES.

4. TEMPORARY INCREASE IN FEDERAL MATCHING PERCENTAGE TO SUPPORT IMPROVED DATA REPORTING SYSTEMS FOR FISCAL YEARS 2018 AND 2019.—In the case of any State that selects as its per capita base period the most recent 2 consecutive quarter period for which necessary (including timely guidance published by the Secretary in the Federal Register) determinations required under this section is available, for amounts expended during calendar quarters beginning on or after October 1, 2017, and each subsequent fiscal quarter, this paragraph shall apply.

(A) Federal matching percentage applied under section 1903(a)(3)(A)(i) shall be...
increased by 10 percentage points to 100 percent; and
(ii) the Federal matching percentage applied under section 1903(a)(2)(B) shall be increased by 25 percentage points to 100 percent; and
(iii) 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 under subsection (i).

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

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

(1) INCENTIVE PAYMENTS FOR HOME AND COMMUNITY-BASED SERVICES.—

(A) IN GENERAL.—The Secretary shall establish a demonstration project under which eligible States may receive incentive payments under this subsection as the ‘demonstration project’ under which eligible States may establish a demonstration project (referred to in this subsection as the ‘demonstration project’) under which eligible States may make HCBS payment adjustments for the purpose of enabling States to provide support and supervision to HCBS enrollees in their homes or in the community.

(B) PROVISION OF PAYMENT ADJUSTMENTS.—Any eligible State that participates in the demonstration project will comply with the health and welfare and federal oversight and evaluating the State’s clinical patient data for quality safety and integrity purposes, including—

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

(ii) birth certificate data; and

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

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

(C) THE PROPOSAL.—The proposal, 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.

(6) REPORTING AND EVALUATION.—

(i) IN GENERAL.—As a condition of receiving the increased Federal medical assistance percentage described in paragraph (4)(B)(i), each eligible State shall collect and report information, as determined necessary by the Secretary, for the purposes of providing Federal oversight of the demonstration project and in such manner as the Secretary may require.

(ii) submit timely and accurate data to the Secretary on adult health quality measures implemented under the program and on information on the quality of health care furnished to program enrollees under the program and in the annual report required under section 1139B(d)(1).

(iii) subm it such additional data and information not described in any of the preceding clauses of this subparagraph but which the Secretary determines is necessary for monitoring, evaluation, or program integrity purposes, including—

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

(B) birth certificate data; and

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

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

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

(B) TERMINATION OF DEMONSTRATION PROJECT.—The demonstration project shall be conducted for the 4-year period beginning on January 1, 2025, and ending on December 31, 2028.

SEC. 132. FLEXIBLE BLOCK GRANT OPTION FOR STATES.

Title XIX of the Social Security Act, as amended by section 132, is further amended by inserting after section 1903A the following new section:

SEC. 1903B. MEDICAID FLEXIBILITY PROGRAM.

(A) IN GENERAL.—Beginning with fiscal year 2023, any State (as defined in subsection (e)) that has an application approved by the Secretary under subsection (b) may conduct a Medicaid Flexibility Program to provide targeted health assistance to program enrollees.

(B) STATE APPLICATION.—

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

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

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

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

(C) The applicable program enrollee category (as defined in subsection (e)(1)).

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

(E) A description of how the State will notify individuals currently enrolled in the State plan for medical assistance to conduct this title of the transition to such program.

(F) Statements certifying that the State agrees to—

(i) submit regular enrollment data with respect to the program to the Centers for Medicare & Medicaid Services at such time and in such manner as the Secretary may require.

(ii) submit timely and accurate data to the Transformed Medicaid Statistical Information System (T-MSIS).

(iii) submit a report annually to the Secretary on adult health quality measures implemented under the program and on information on the quality of health care furnished to program enrollees under the program and in the annual report required under section 1139B(d)(1).

(iv) subm it such additional data and information not described in any of the preceding clauses of this subparagraph but which the Secretary determines is necessary for monitoring, evaluation, or program integrity purposes, including—

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

(B) birth certificate data; and

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

(v) on an annual basis, conduct a report evaluating the program and make such report available to the public.

(G) An information technology systems plan demonstrating that the State has the capability to support the technological advances and other requirements of the plan with reporting requirements under this section.

(H) A statement of the goals of the 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.

(1) SUCH OTHER INFORMATION AS THE SECRETARY MAY REQUIRE.

(3) STATE NOTICE AND COMMENT PERIOD.—

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

(B) NOTICE AND COMMENT PROCESS.—During the notice and comment period described in subparagraph (A), the State shall provide public 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.

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

(2) DEADLINES.—Each year beginning with 2019, the Secretary shall specify a deadline for submission of an application to conduct a Medicaid Flexibility Program that would begin in the fiscal year following the date on which the application is submitted.

(3) FEDERAL PAYMENT AND STATE MAINTENANCE OF EFFORT EXPENDITURES.—For each year during which a State is conducting a Medicaid Flexibility Program, the State shall receive, in addition of amounts otherwise payable to the State under this title for medical assistance for program enrollees, the amount specified in paragraph (9)(A).

(A) IN GENERAL.—The block grant amount under this paragraph for a State and year shall equal the sum of the amount determined under subparagraph (B) for each 1903A enrollee category within the applicable program enrollee category for the State and year.

(B) ENROLLEE CATEGORY AMOUNTS.—

(i) For initial year.—Subject to subparagraph (C), for the first fiscal year in which a 1903A enrollee category is included in the applicable program enrollee category for a Medicaid Flexibility Program conducted by the State, the amount determined under this subparagraph shall equal the Federal average medical assistance matching percentage (as defined in section 1903A(a)(4)) of the amount determined for the State and category for the second fiscal year for the succeeding fiscal year if the amount determined for the State and year exceeds the amount determined for the State and year for the succeeding fiscal year.

(ii) For any subsequent year.—For any fiscal year that is not the first fiscal year in which a 1903A enrollee category is included in the applicable program enrollee category for a Medicaid Flexibility Program conducted by the State, the block grant amount under this subparagraph shall be the amount determined for the State, year, and category that would be equal to the amount determined for the State and category for the most recent previous fiscal year in which the State was conducting a Medicaid Flexibility Program that included such category, except that such amount shall be increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) from April of the second fiscal year preceding the fiscal year involved to April of the fiscal year involved.

(C) CAP ON TOTAL POPULATION OF 1903A ENROLLEES FOR PURPOSES OF BLOCK GRANT CALCULATION.—

(i) IN GENERAL.—In calculating the amount of a block grant for the first year in which a 1903A enrollee category is included in the applicable program enrollee category for a Medicaid Flexibility Program conducted by the State under subparagraph (B)(i), the total number of 1903A enrollees in such 1903A enrollee category for the State and year shall not exceed the adjusted number of base period enrollees for the State (as defined in clause (ii)).

(ii) ADJUSTED NUMBER OF BASE PERIOD ENROLLEES.—The term ‘adjusted number of base period enrollees’ means, with respect to a State and 1903A enrollee category, the sum of the amount of enrollees for the State’s per capita base period (as determined under section 1903A(e)(4)), increased by the percentage increase in the total State population (as determined using the best available data from the Bureau of the Census) plus 3 percentage points.

(iii) USE OF FUNDS.—Funds made available to a State under this subparagraph shall only be used for expenditures related to the State plan under section 1115 of the Social Security Act provided under the block grant (reduced, in the case of a State not complying with the requirements of this section, by the amount of Federal payments made to the State under this title).

(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 conduct such a 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, and shall publish such determinations not later than June 1 of each
year.

(d) 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
continued for succeeding program periods
without resubmitting an application under
subsection (b), provided that:

(I) this section provides notice to the Sec-
retary of its decision to continue the pro-
gram; and

(II) to significant changes are made to the
program; and

(iii) shall be subject to termination only
by the State, 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.

(iii) EFFECT OF TERMINATION.—If a State
election 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.

(3) PROVISION OF TARGETED HEALTH ASSIST-
ANCE.—

(A) IN GENERAL.—A State Medicaid Flexi-
bility Program shall provide targeted health assistance to program enrollees and such as-
sistance shall be provided in a manner that
would otherwise be provided to the enrollees under this title.

(B) CONDITIONS FOR ELIGIBILITY.—

(A) IN GENERAL.—A State conducting a
Medicaid Flexibility Program shall establish conditions for eligibility of program enrol-
ees, which shall be instead of other condi-
tions under this title, except that the program must provide for eligibility
for program enrollees to whom the State
would otherwise be required to make med-
ical assistance available under section

(ii) MAGI.—Any determination of income
necessary to establish the eligibility of a
program enrollee under this paragraph shall not apply to a rebate agreement that complies with the requirements of section 1927, and any re-
quirements applicable to medical assistance
for covered outpatient drugs under a State
plan (including the requirement that the
State provide information to a manufac-
turer) shall apply in the same manner to

(i) PRESCRIPTION DRUGS.—If the targeted
health assistance provided by a State to
program enrollees under a Medicaid Flexi-
Bility Program includes assistance for covered
outpatient drugs, such drugs shall be subject to a re-
bate agreement that complies with the
requirements of section 1927, and any re-
quirements applicable to medical assistance
for covered outpatient drugs under a State
plan (including the requirement that the
Secretary deems appropriate, shall not apply.

(3) DEFINITIONS.—For purposes of this sec-
ction:

(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) and (E) of section 1903A(e)(2).

(C) NONELDERLY, NONDISABLED, NONEXPAN-
SION ADULTS.—The 1903A enrollee category
described in subparagraph (E) of section
1903A(e)(2).

(2) MEDICAID FLEXIBILITY PROGRAM.—The
term ‘Medicaid Flexibility Program’ means a

annual aggregate amount of all such charges
imposed with respect to all program enrol-
lees in a family shall not exceed 5 percent of
the family’s income for the year involved.

(3) BENEFICIARY PROTECTIONS.—Establish
a fair process (which the State shall describe
in the application required under subsection
(b)) for individuals to appeal adverse eligi-

(2) MEDICAID FLEXIBILITY PROGRAM.—The
Medicaid Flexibility Program shall provide as
targeted health assistance the following types of services:

(i) Inpatient and outpatient hospital serv-
ices.

(ii) Laboratory and X-ray services.

(iii) Nurse facility services for individ-
uals aged 21 and older.

(iv) Physician services.

(v) Home health services (including
home nursing services, medical supplies,
equipment, and appliances).

(vi) Rural health clinic services (as de-
efined in section 1905(l)(3)).

(vii) Federally-qualified health center
services (as defined in section 1905(l)(2)).

(viii) Family planning services and sup-
plies.

(ix) Nurse midwife services.

(x) Certified pediatric and family nurse
practitioners and nurse practitioners.

(xi) Freestanding birth center services
(as defined in section 1905(l)(3)).

(xii) Emergency medical transportation.

(xiii) Non-cosmetic dental services.

(xiv) Pregnancy-related services, includ-
ing postpartum services for the 12-week pe-
riod beginning on the last day of a preg-
nancy.

(2) MEDICAID FLEXIBILITY PROGRAM.—The
Medicaid Flexibility Program shall provide as
targeted health assistance the following types of services:

(i) Inpatient and outpatient hospital serv-
ices.

(ii) Laboratory and X-ray services.

(iii) Nurse facility services for individ-
uals aged 21 and older.

(iv) Physician services.

(v) Home health services (including
home nursing services, medical supplies,
equipment, and appliances).

(vi) Rural health clinic services (as de-
efined in section 1905(l)(3)).

(vii) Federally-qualified health center
services (as defined in section 1905(l)(2)).

(viii) Family planning services and sup-
plies.

(ix) Nurse midwife services.

(x) Certified pediatric and family nurse practit-
ioneers and nurse practitioners.

(xi) Freestanding birth center services
(as defined in section 1905(l)(3)).

(xii) Emergency medical transportation.

(xiii) Non-cosmetic dental services.

(xiv) Pregnancy-related services, includ-
ing postpartum services for the 12-week pe-
riod beginning on the last day of a preg-
nancy.

(2) MEDICAID FLEXIBILITY PROGRAM.—The
Medicaid Flexibility Program shall provide as
targeted health assistance the following types of services:

(i) Inpatient and outpatient hospital serv-
ices.

(ii) Laboratory and X-ray services.

(iii) Nurse facility services for individ-
uals aged 21 and older.

(iv) Physician services.

(v) Home health services (including
home nursing services, medical supplies,
equipment, and appliances).

(vi) Rural health clinic services (as de-
efined in section 1905(l)(3)).

(vii) Federally-qualified health center
services (as defined in section 1905(l)(2)).

(viii) Family planning services and sup-
plies.

(ix) Nurse midwife services.

(x) Certified pediatric and family nurse practit-
ioneers and nurse practitioners.

(xi) Freestanding birth center services
(as defined in section 1905(l)(3)).

(xii) Emergency medical transportation.

(xiii) Non-cosmetic dental services.

(xiv) Pregnancy-related services, includ-
ing postpartum services for the 12-week pe-
riod beginning on the last day of a preg-
nancy.
State program for providing targeted health assistance to program enrollees funded by a block grant under this section.

(3) Program enrollment.—

(A) Definition.—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)(1) enrollee (as defined in section 1903A(e)(1)) who is in the applicable program enrollment category specified by the State for the period.

(B) Period 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 for and to be 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) States; ‘State’ means one of the 50 States or the District of Columbia.

(6) Targeted health assistance.—The term ‘targeted health assistance’ means assistance (or reinsurance or insurance or medical services for program enrollees)."

SEC. 134. Medicaid and CHIP quality performance bonus payments.

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

(b) Quality performance bonus payments.—

(1) Increased Federal share.—With respect to each of fiscal years 2023 through 2026, the Secretary of each of the 50 States or the District of Columbia (each referred to in this subsection as a ‘State’) may—

(A) equals or exceeds the qualifying amount (as established by the Secretary) of lower than expected aggregate medical assistance expenditures (as defined in paragraph (4)) for that fiscal year; and

(B) 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, determines that—

(i) information on the applicable quality measures identified under paragraph (3) with respect to each category of Medicaid eligible individual enrolled in the State plan or a waiver of such plan, and

(ii) a plan for spending a portion of additional funds resulting from application of this subsection on quality improvement within the State plan under this title or under a waiver of such plan, the Federal matching percentage otherwise applicable under section 1902(a)(7) 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) Allocation and determination.—The Secretary shall establish a formula for computing State allotments under this paragraph for each fiscal year described in paragraph (1) for calculating the Federal share of the resulting medical assistance expenditures (within the State plan under title XIX of the Social Security Act) for such fiscal year.

(A) such an allotment to a State is determined based on the performance, including improvement, of such State under this title and to the extent to the extent that the applicable quality measures submitted under paragraph (3) by such 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 years described 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 as necessary) peer-reviewed quality measures (which shall include health care and long-term care outcome measures and may include measures that are reviewed or developed by the National Committee for Quality Assurance or the Agency for Healthcare Research and Quality or that are identified under section 1933A(a)(i) or section 1933B(a)(1) that are quantifiable, objective measures that take into account the clinically appropriate measures of quality for different types of services inside, outside, or partially inside a State's Medicaid Flexibility Program.

(4) Program period.—An application described in section 1903A(e)(2)(E); is less than

(A) the amount of the adjusted total medical assistance expenditures for the State and fiscal year determined in section 1903A(e)(2)(E); or

(B) the amount of the total medical assistance expenditures for the State and fiscal year determined in section 1903A(e)(2)(E).

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

SEC. 135. Grandfathering certain Medicaid waivers; prioritization of HCBS.

(a) Managed Care Waivers.—

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

(b) HCBS waivers.—(1) In general.—If a State with a grandfathered managed care waiver submits an application for approval of a new waiver under such modified terms and conditions described in section 1903A(f)(1) of the Social Security Act or a waiver of such plan without submitting an application to the Secretary for a new waiver to implement such managed care delivery system, the Secretary or the Secretary’s designee shall, in determining whether to approve such waiver, consider such factors as the Secretary determines to be relevant.

(2) Modifications.—(A) In general.—If a State with a grandfathered managed care waiver submits an application for approval of a new waiver under such modified terms and conditions described in section 1903A(f)(1) of the Social Security Act or a waiver of such plan, the Secretary shall, to the extent practicable, modify the terms or conditions of such a waiver, the State shall submit to the Secretary an application for approval of a new waiver under such modified terms and conditions.

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

(A) a denial; or

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

(ii) Additional information.—If the Secretary requests additional information, the Secretary shall provide to the individual whose application is in sub-paragraph in response to the Secretary’s request to deny the application or request more information.

(iii) Grandfathered managed care waiver defined.—In this subsection the term ‘grandfathered managed care waiver’ means the provisions of a waiver or an experimental, pilot, or demonstration project that relate to the authority of a State to implement a managed care delivery system under the State plan under title XIX of the Social Security Act (or under such terms and conditions that—

(A) is approved by the Secretary of Health and Human Services under section 1933A(b), 1932, or 1115(a)(1) of the Social Security Act (42 U.S.C. 1396a(b), 1396a-2, 1315(a)(1)) as of January 1, 2017; and

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

(3) Coordination with States.

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

“Coordination with States—

SEC. 1904A. No proposed rule (as defined in section 551(4) of title 5, United States Code) implementing section 1933A of the Social Security Act that—

(A) the Secretary submits to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives for approval; or

(B) the Secretary requests additional information in response to the Secretary’s request to deny the application or request more information.

(iii) For purposes of subsection (a)(16)(C), the term ‘qualified inpatient psychiatric services under the Medicaid plan under this title’ means inpatient psychiatric services under a Medicaid plan under section 1902 of the Social Security Act (42 U.S.C. 1396a).”
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)(15)(A) and are furnished—

(A) in an institution (or distinct part thereof) which is a psychiatric hospital (as defined in section 1396d(b)(1)) 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)(15)(C), the State must—

(a) maintain as of the date the State applies to the Secretary to include medical assistance under such subsection—

(A) 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 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.

(b) SPECIAL MATCHING RATE.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by adding at the end the following:

Notwithstanding the previous provisions of this subsection, the Federal medical assistance percentage shall be 50 percent with respect to medical assistance for services and individuals described in subsection (a)(15)(C).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to qualified inpatient psychiatric hospital services furnished on or after October 1, 2018.

SEC. 138. EMPLOYEE FUND FOR MEDICA L ASSISTANCE TO ELIGIBLE INDIGENS.

Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended in the third sentence, and with subsection (a) thereof, by inserting at the end the following:

“Notwithstanding the previous provisions of this subsection, the Federal medical assistance percentage shall be 50 percent with respect to medical assistance for services and individuals described in subsection (a)(15)(C).

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

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

“SEC. 1906B. (A) IN GENERAL.—A State may elect to provide cost-sharing assistance (as defined in subsection (c)) for an eligible low-income individual (as defined in subsection (b)) with respect to medical assistance under this title on a sliding scale based on income and percentage of full actuarial value that the State may determine.

(B) ELIGIBLE LOW-INCOME INDIVIDUAL DEFINED.—For purposes of this section, the term ‘eligible low-income individual’ means an individual—

(i) whose income (as determined under section 1902(a)(14)) does not exceed 133 percent of the Federal poverty line (as defined in section 6102(c)(6)) applicable to a family of the size involved;

(ii) who is eligible for premium assistance for purposes of a qualified health plan under section 36B of the Internal Revenue Code of 1986 and is enrolled in such a plan;

(iii) who is described 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, cost-sharing assistance shall be considered to be ‘cost-effective’ with respect to a State if the aggregate amount of Federal cost-sharing and premium assistance (as defined in paragraph (2)) for the State and year exceed the Federal cost-sharing assistance limit (as defined in paragraph (3)) for the State and year, and exceed the Federal cost-sharing and premium assistance limit (as defined in paragraph (3)) for the State and year, cost-sharing assistance shall be equal to the Federal average medical assistance matching percentage (as defined in section 1903A(a)(4)) for such State and year; and

(B) in no case shall the amount of Federal payments made to a State for a year with respect to amounts expended for such assistance exceed the amount of cost-sharing assistance limit for the State and year applicable under subsection (d)(3).

(2) SCALING OF ASSISTANCE.—A State may provide cost-sharing assistance under this section on a sliding scale based on income and percentage of full actuarial value that the State may determine.

(3) NONAPPLICATION OF MINIMUM ESSENTIAL COVERAGE.—Cost-sharing assistance provided under this section shall not be considered to be minimum essential coverage (as defined in section 1902A(f) of the Internal Revenue Code of 1986).

(4) NONAPPLICATION OF OTHER REQUIREMENTS.—Sections 1902(a)(1) (relating to state plan requirements), 1916, and 1916A (relating to state plan requirements), and any other provision of this title which would be disregarded for purposes of this section shall not apply to the provision of cost-sharing assistance under this section.”.

SEC. 140. SMALL BUSINESS HEALTH PLANS.

(a) TAX TREATMENT OF SMALL BUSINESS HEALTH PLANS.—A small business health plan (as defined in section 2701 of the Public Health Service Act (42 U.S.C. 300gg–91) for purposes of applying title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) and title XXII of such Act (42 U.S.C. 300bb–1); and

(b) as a group health plan (as defined in section 5009(b)(1) of the Internal Revenue Code of 1986) for purposes of applying sections 4980B and 5000 and chapter 100 of the Internal Revenue Code of 1986; and


(b) RULES.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021 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) SPONSOR.—The sponsor of a group health plan is described in this subsection if such sponsor—

(i) is a qualified sponsor and receives certification by the Secretary;

(ii) 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;

(iii) is established as a permanent entity;

(iv) 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 7701(e) corporation; and

(v) does not condition membership on the basis of a minimum group size.
(a) FILING FEE.—A small business health plan sponsor 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; and

(D) shall conduct oversight of certified plan sponsors, including periodic review, and consists of such 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, the applicable State authority under sections 502 and 504.

(2) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

(A) Identifying information.

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

(C) Bonding requirements.

(D) Plan documents.

(E) Agreements with service providers.

(3) REQUIREMENTS FOR CERTIFIED PLAN SPONSORS.—Not later than 6 months after the date of enactment of this part, the Secretary shall issue an interim final rule requiring certified plan sponsors that include requirements regarding—

(A) structure and requirements for boards of trustees, plan administrators, and plan sponsors; (B) notification of material changes; and

(C) notification for voluntary termination.

(4) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed by the plan sponsor with the applicable State authority 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 of not more than $10,000 against any officer, director, or employee of a plan sponsor (or any dependent, as defined under paragraphs (a) and (b)) 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 individual who is such 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

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

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

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

(5) PARTICIPATING EMPLOYER.—In applying requirements relating to coverage renewal, a participating employer shall not be deemed to be a plan sponsor.

(6) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to a small business health plan if—

(1) under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any individual who is such employer with or without employees or any dependent, as defined under paragraphs (a) and (b);

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

(7) SECTION 705 ORGANIZATION.—The term ‘section 705 organization’ means an organization providing services for a consumer 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 705 organization control group. For purposes of this part, any reference to ‘member’ shall include a customer of a section 705 organization except with respect to references to a ‘member’ or ‘members’ in paragraph (1).

(8) SAVINGS CLAUSE.—Section 781(c) of such Act is amended by inserting ‘or part 8’ after ‘this part’.

(9) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year 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 year not otherwise obligated”;

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

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

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 opioid and substance abuse crises.

Funds appropriated under this section shall remain available until expended.

SEC. 203. COMMUNITY HEALTH CENTER PROVISIONS.

Effective as if included in the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10, 129 Stat. 419), paragraph (1) of section 221(a) of the Public Health Service Act is amended by inserting “, and an additional $22,000,000 for fiscal year 2017” after “2017”.

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

Section 2701(a)(1)(A)(i) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)(i)) is amended by inserting after “consistent with section 2701(c)” the following: “or, for plan years beginning on or after January 1, 2019, 5 to 1 for adults (consistent with section 2707(c))” as the State may determine.

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

Section 2701(b) of the Public Health Service Act (42 U.S.C. 300gg–1(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 references to 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) ENFORCEMENT OF WAITING PERIODS.—Section 2702(b)(1) of the Public Health Service Act (42 U.S.C. 300gg–1(b)(1)) is amended by inserting “, and as described in paragraph (3)” before “before”.

(b) CREDIBLE COVERAGE REQUIREMENT.—Section 2702(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–1(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),” inserting “in accordance with this subsection”; and

“(B) by redesignating such paragraph as paragraph (4); and

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

“(3) WAITING PERIODS.—

“(A) IN GENERAL.—The term ‘creditable coverage’ that is effective on or after January 1, 2017, a health insurance issuer described in subsection (a) that offers such coverage in the individual market shall impose a 4 month waiting period (as defined in the same manner as such term is defined in section 2702(b)(4) for group health plans) on any individual who enrolls in such coverage and who cannot demonstrate—

“(i) in the case of an individual submitting an application during an open enrollment period, 12 months of continuous creditable coverage unless (I) the individual submits an application prior to the date of the adoption, and (II) the individual demonstrates coverage beginning on the date of the adoption; or

“(ii) in the case of an individual submitting an application during a special enrollment period—

“(I) 12 months of continuous creditable coverage as described in clause (i); or

“(II) 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 date 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 for which the individual qualifies, coverage under the plan begins on the first day of the calendar month that is 6 months after the date on which the individual submits an application for health insurance coverage; and

“(ii) in 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 submitted 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 certification of periods 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’ has the meaning given such term in section 2702(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 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 adoption.

“(III) Other individuals, as the Secretary determines appropriate.

SEC. 207. WAIVERS FOR STATE INNOVATION.

(a) IN GENERAL.—Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18002) is amended—

(1) in subsection (a)—

“(A) in paragraph (1)—

“(i) in subparagraph (B)—

“(I) by amending clause (1) to read as follows:—

“(ii) by adding after the second sentence the following:—

“(A) to the extent that such State plan does not increase the Federal deficit; and

“(B) in subparagraph (C), by striking “the law or has in effect a certification” and inserting “a law and

“(ii) by adding after the second sentence the following:—

“(A) to the extent that such State plan does not increase the Federal deficit; and

“(B) in subparagraph (C), by striking “the law or has in effect a certification” and inserting “a law and

“(ii) by adding at the end the following:

“(B) 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.

“(C) AUTHORITY TO USE LONG-TERM STATE INNOVATION AND STABILITY ALLOTMENT.—If the State has an application for an allotment under section 2105(s) 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 the State plan under this section, so long as such use is consistent with the requirements of paragraphs (1) and (2) of section 2105(s) of such Act (other than paragraph (4) of such section). Any funds used to carry out a State plan under this subparagraph shall not be
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 required to respond to an urgent or emergency situation with respect to health insurance coverage within a State.’’.

(2) in subsection (b), by striking the period at the end of paragraph (6) and inserting the following: ‘‘may terminate the Federal deficit, not taking into account any

(a)(1) or that the State plan will increase the

missing a required element under subsection paragraph (D) and inserting ‘‘application is

shall establish an expedited application and

plan increases the Federal deficit.’’; and

(b) E FFECTIVE DATE.—The repeal made by

SEC. 209. APPLICATION OF ENFORCEMENT PEN-

(a) in paragraph (1)(A)(II), by inserting ‘‘OF OPT OUT’’; and

SEC. 202. CONDITIONS FOR RECEIVING ADDI-

(b) in paragraph (2), by inserting ‘‘and in-

(c) N ON-APPLICABLE PROVISIONS DE-

(iii) in subparagraph (B)—

(ii) in subparagraph (A), by inserting ‘‘and in-

(i) in paragraph heading, by inserting ‘‘CERTIFY’’ after ‘‘LAW’’;

(ii) in subparagraph (A), by inserting before

waiver under this section, including the im-

shall apply to such application and State plan.

and the reasons therefore, and provide the data

with respect to the State by—

shall apply to such application and State plan.

the authority provided under the waiver

and inserting the following: ‘‘may terminate

may not be cancelled by the Secretary

increases the Federal deficit.’’; and

the applicable State health insurance re-

enrollees in cata-

strophic plans described in section 1302(e)’’ after ‘‘Exchange’’.

(ii) by striking ‘‘plan—’’ and all that fol-

(i) in the matter preceding subparagraph (A)—

(ii) by striking ‘‘only if’’ and inserting

‘‘shall’’; and

‘‘shall’’; and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and

and
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 for any health insurance coverage offered in accordance with subsection (a) or to make payments to such issuer of such coverage offered in accordance with subsection (a).

(g) FUNDING FOR STATES.—(1) APPROPRIATION.—There is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated, $2,000,000,000 for the period beginning on January 1, 2020, and ending on December 31, 2026, for the purpose of providing allotments for States in which a health insurance issuer offers coverage in accordance with subsection (a). Amounts paid to any such State from such an allotment shall be used to offset costs attributable to the State’s regulation and oversight of such coverage and shall be available under this paragraph until expended.

(2) PROCEDURE FOR DISTRIBUTION OF FUNDS.—The Secretary of Health and Human Services shall determine an appropriate procedure for providing and distributing funds under this subsection.

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

SA 271. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. McCONNELL to the bill H.R. 1628, to title II of the concurrent resolution on the budget for fiscal year 2017, as follows:

Strike all after the first line and insert the following:

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

TITI I
SEC. 101. RECAPTURE EXCESS ADVANCE PaymentMENTS OF PREMIUM TAX CREDITS.
Subparagraph (B) of section 36B(c)(2)(A) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

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

SEC. 102. PREMIUM TAX CREDIT.
(a) IN GENERAL.—(1) DEFINITION OF QUALIFIED HEALTH PLAN.—(A) IN GENERAL.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986 is amended by inserting before the period at the end the following: “or a plan that includes coverage for abortions, other than an abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest.”

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

(2) REMOVAL OF ELIGIBILITY DETERMINATIONS.—(1) IN GENERAL.—The following sections of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) shall not be permitted to use pass through funding under subsection (a)(3) or of such section either to provide assistance to individuals who enroll in health insurance coverage offered in accordance with subsection (a) or to make payments to issuers of such coverage offered in accordance with subsection (a).

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

SEC. 103. SMALL BUSINESS TAX CREDIT.
(a) SUNSET.—(1) IN GENERAL.—Section 45R of the Internal Revenue Code of 1986 is amended by adding at the end the following new 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 5000A(a)(1) of the Internal Revenue Code of 1986 is amended—

(1) in paragraph (1)(B)(v), by striking “2.5 percent” and inserting “Zero percent”; and

(2) in paragraph (3)—

(A) by striking “$6085” in subparagraph (A) and inserting “$9”, and

(B) by striking subparagraph (D).

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

SEC. 105. EMPLOYER MANDATE.
(a) IN GENERAL.—(1) Paragraph (1) of section 4980H(b) of the Internal Revenue Code of 1986 is amended by inserting “$0 in the case of months beginning after December 31, 2015” after “$2,000.”

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

SEC. 106. FEDERAL PAYMENTS TO STATES.
(a) IN GENERAL.—Notwithstanding section 50A(a), 1902(a)(23), 1903(a), 2002, 2005(a)(4), 2016(a)(24), 2018, or 2106, the Patient Protection and Affordable Care Act (42 U.S.C. 17904(a)), 1369A(b), 1397a, 1397d(a)(4), 1397b(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 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 to provide as a payment to a prohibited entity, whether directly to the prohibited entity or through a managed care organization under contract with such entity.

(b) DEFINITIONS.—In this section:

(1) PROHIBITED ENTITY.—The term “prohibited entity” means an entity, including its affiliates, subsidiaries, successors, and clinics, that provides for abortions, other than an abortion to prevent a lapse in coverage if a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself, and for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act in fiscal year 2014 made directly to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $1,000,000.

(2) DIRECT SPENDING.—The term “direct spending” has the meaning given to that term under section 259(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900(c)).

SEC. 107. MEDICAID.
The Social Security Act (42 U.S.C. 301 et seq.) is amended—

(1) in section 1992, by—

(A) in subsection (a)(4)(B)(i), by striking “2.5 percent” and inserting “Zero percent”;

(B) by striking paragraph (3)—

(i) in the first sentence of subsection (b), by striking “2.5 percent” and inserting “Zero percent”;

(ii) by striking “(B),” and

(iii) in subsection (c)(2), by inserting “or paragraph (1)” after “in clause (ii)”;

(2) CARRYING OUT;—The term “carrying out” means to make payments to a prohibited entity, whether directly to the prohibited entity or through a managed care organization under contract with such entity.

SEC. 108. AMENDMENTS TO THE BUDGET FOR FISCAL YEAR 2018.
(a) IN GENERAL.—Except as provided otherwise in this Act, amendments made by this section—

(1) in section 250(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900(c))—

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to fiscal years beginning after December 31, 2018.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect after December 31, 2019.
SEC. 108. REPEAL OF DSH ALLOTMENT REDUCTIONS.

Section 1921(g) of the Social Security Act (42 U.S.C. 1396n–4(f)) is amended by striking subsection (i).

SEC. 109. 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 AND HEALTH REIMBURSEMENT ARRANGEMENTS.—The amendment made by subsection (a) shall not apply to taxable years beginning after December 31, 2019.

(d) EFFECTIVE DATES.—

(1) DISTRIBUTE FROM SAVINGS ACCOUNTS.—The amendments made by subsection (a) and (b) shall apply to amounts received by such individual with respect to em-

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

SEC. 111. REPEAL OF REPEAL OF TAX ON OVER-THE-COUNTER MEDICATIONS.

(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 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 taxable years beginning after December 31, 2017.

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, 2017.

SEC. 113. REPEAL OF 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 sentence:

“(i) 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 PERSONAL USE.

(a) IN GENERAL.—Section 192 of the Internal Revenue Code of 1986 is amended by adding after “such deduction” the following new sentence:

“(ii) DEDUCTION FOR PERSONAL USE.—There shall be allowed as a deduction, subject to the rules of section 212, with respect to any amount allocable to personal use, the smaller of such amount or the amount excluded under section 105 of the Internal Revenue Code of 1986 by reason of section 212(f).”

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

SEC. 117. REPEAL OF MEDICARE TAX INCREASE.

(a) IN GENERAL.—Section 110 of the Patient Protection and Affordable Care Act is amended by striking “February 17, 2010, and ending before January 1, 2018.”

(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 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. 119. REPEAL OF MEDICARE TAX INCREASE.

(a) IN GENERAL.—The Internal Revenue Code of 1986 is amended by adding after “2016” the following new sentence:

“(i) APPLICABILITY.—The tax imposed by this subsection shall apply to taxable years beginning after December 31, 2016, and ending before January 1, 2018.”

(b) EFFECTIVE DATE.—The amendment 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 services performed after September 30, 2017.

SEC. 121. REMUNERATION.

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

“(I) TERMINATION.—This paragraph shall not apply to taxable years beginning after December 31, 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. 300u–11) is amended—

(1) by striking “‘2017’”.

(2) by striking paragraphs (3), (4) in section 4101 of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence:

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

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 that have an incidence of substance abuse or substance use disorders or mental health needs that is substantial relative to other States or to States that have an incidence of substance abuse or substance use disorders or mental health needs that is substantial relative to their own communities that are urgent relative to such needs. 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 disorder or mental health disorders.

(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. 87, section 1001) is amended by striking “, and an addi-

SEC. 204. FUNDING FOR COST-SHARING PAYMENTS.

There is appropriated to the Secretary of the Treasury and 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, 2015, for purposes of this Act, payments and other actions for adjustments to any obligations inured 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 272. Mr. JOHNSON submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. 1. SUNSET OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010.—Effective with respect to plan years beginning on or after January 1, 2020, the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), including the amendments made by such Act, shall have no force or effect.

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. SHORT TITLE.

(a) Self-Only Coverage.—Section 223(b)(2) 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)".

(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)".

(c) Cost-Of-Living Adjustment.—Section 223(g)(1) of such Code is amended—

(1) by striking "subsections (b)(2) and (b) places it appears and inserting "subsection", and (2) in subparagraph (B), by striking "determined by" and all that follows through "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. 2. FINDINGS.

(a) Allow All Individuals Purchasing Health Insurance in the Individual Market the Option to Purchase a Lower Premium Catastrophic Plan.

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:

"(4) 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 1322(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18052(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 1322(c)" after "Exchange"; and (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 1322(c)" after "Exchange".

SA 276. Mr. KAINE (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:

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) 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)".

(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)".

(c) Cost-Of-Living Adjustment.—Section 223(g)(1) of such Code is amended—

(1) by striking "subsections (b)(2) and (b) places it appears and inserting "subsection", and (2) in subparagraph (B), by striking "determined by" and all that follows through "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.

Congress makes the following findings:

(1) Before the passage of the Patient Protection and Affordable Care Act (Public Law 114–148) in 2010, Americans with pre-existing conditions faced unfair barriers to accessing health insurance coverage and health care costs had risen rapidly for decades.

(2) Since 2010, the rate of uninsured Americans has declined to a historic low, with more than 20,000,000 Americans gaining access to health insurance coverage.

(3) Since 2010, America has experienced the slowest growth in the price of health care in over five decades.

(4) Thanks to the Patient Protection and Affordable Care Act (Public Law 114–148), millions can no longer be denied insurance or charged more on the basis of their health status, more Americans than ever have insurance, and the health care they receive is continually improving.

(5) Starting in 2016, independent, non-partisan organizations, including the Congressional Budget Office, have determined that individual, business, and insurance markets have stabilized and improved.

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.

(7) Risk mitigation programs, such as the reinsurance program for the Medicare Part D prescription drug benefit program, have provided additional stability to 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 stabilise the new insurance marketplaces and reduced insurance premiums in the individual health insurance market by as much as 10 percent.

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 costs, and higher 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, with much better service treatment, a plan where you can have access to the doctor that you want and the plan that you want. We're
Mr. KAINE 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 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 within the City of Alexandria, Virginia, known as the ‘Nevius Tract’ and transferred to the Department of the Interior in 1953, that is bounded generally by—

(1) Arlington Boulevard (United States Route 50) to the north;
(2) Jefferson Davis Highway (Virginia Route 110) to the east;
(3) the rail line 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 Act for Fiscal Year 2002 (Public Law 107–107; 115 Stat. 1332), the Secretary of the Interior may construct a structure for visitor services, including a parking lot, 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.

(a) Definition.—In this section:

(1) by striking ’’issued under’’ and inserting ’’issued—’’;
(2) by striking ’’and on’’ and inserting ’’and’’;
(3) by striking ’’requirements.’’ and inserting ’’requirements’’; and
(4) by adding at the end the following new paragraph:

’’(2) under section 9 of the Small Business Act (15 U.S.C. 638), and on compliance with the following: ’’issued—’’;

(b) Modifications of Definition of Qualified Health Plan.—

(1) In General.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

’’(iii) Nonapplicability of limitation.—This subparagraph shall not apply to taxable years ending after December 31, 2017, and before January 1, 2020.’’.

SEC. 102. PREMIUM TAX CREDIT.

(a) Premium Tax Credit.—

(1) Modification of Definition of Qualified Health Plan.—

(A) In General.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986 is amended by striking the following: ’’or 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).’’.

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

(c) Small Business Tax Credit.—

(1) In General.—Section 502(a) of the Internal Revenue Code of 1986 is amended by—

(A) by striking ’’2.5 percent’’ and inserting ’’Zero percent’’; and

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

’’(ii) In General.—Subpart C of part IV of chapter 1 of the Internal Revenue Code of 1986 is amended—

(A) in subsection (c)(1), by striking ’’$2,000’’ and inserting ’’$0’’;

(B) in subsection (c)(2), by striking ’’$0’’ and inserting ’’$2,000’’;

(C) in subsection (c)(3), by striking ’’$0’’ and inserting ’’$2,000’’;

(D) in subsection (d)(1), by striking ’’$3,000’’ and inserting ’’$2,000’’;

(E) in subsection (d)(2), by striking ’’$3,000’’ and inserting ’’$2,000’’; and

(F) in subsection (d)(3), by striking ’’$3,000’’ and inserting ’’$2,000’’. ’’

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

(b) Disallowance of Small Employer Health Insurance Coverage.—

(1) In General.—Section 500A(c) of the Internal Revenue Code of 1986 is amended by

(A) by striking ’’Any term’’ and inserting the following:

’’(j) Any term’’;

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

’’(2) Exclusion of Health Plans Including Coverage for Abortion.—The term ‘qualified health plan’ does not include any health plan that includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).’’.

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

’’(iii) Nonapplicability of limitaton.—This subparagraph shall not apply to taxable years ending after December 31, 2017, and before January 1, 2020.’’.

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

(c) Individual Mandate.—

(1) In General.—Section 5000A(b) of the Internal Revenue Code of 1986 is amended by

(A) in paragraph (2)(B)(iii), by striking ’’2.5 percent’’ and inserting ’’Zero percent’’; and

(B) in paragraph (3)(D)(i), by striking ’’4695’’ in subparagraph (A) and inserting ’’”0’’, and

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

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

SEC. 105. EMPLOYER MANDATE.

(a) In General.—

(1) Paragraph (1) of section 4980H(c) of the Internal Revenue Code of 1986 is amended by inserting ’’(30 in the case of months beginning after December 31, 2015)’’ after ’’(32,000)’’.

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

SEC. 106. FEDERAL PAYMENT STATES.

(a) In General.—Notwithstanding section 504(a), 1902(a)(23), 1903(a), 2002, 2005(a)(4), 2102(a)(7), or 2106(a)(1) of the Social Security Act (42 U.S.C. 704(a), 1396a(a)(23), 1396b(a), 1397a, 1397d(a)(4), 1397b(a)(7), 1397e(a)(1)), or the terms of any Medicaid waiver in effect on the date of enactment of this Act that is approved under section 1115 of the Social Security Act (42 U.S.C. 1315, 1396a), for the 1-year period beginning on the date of enactment of this Act, no Federal funds provided under this Act shall be used to pay any amount that is made directly to a 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 clinical.

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

(1) is an organization described in section 501(a)(1) 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 providing health, related medical care; and (iii) provides for abortions, other than an abortion—

(I) in the case of a normal 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 has its origin or increases during pregnancy and which may cause the woman's death or a physical disability that is likely to result in a physical disorder, physical injury, or physical illness that would have caused her death or a physical disability that is likely to result in a disability which is a substantial risk to the health of the woman if the pregnancy were carried to term; or

(iii) in the case of a woman in an advanced physical condition, is necessary to preserve the life of the woman if she sustains a physical illness or injury that would have caused her death if she were not pregnant.

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) Archers.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by striking “Such term” and all that follows through the period.

(c) Health Flexible Spending Arrangements and Health Reimbursement Arrangements.—Section 106 of the Internal Revenue Code of 1986 is amended by striking subsection (f).

(d) Effective Dates.—

(1) Distributions from Savings Accounts.—The amendments made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2016.

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

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.—Section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “20 percent” and inserting “15 percent”.

(c) Effective Date.—The amendments made by this section shall apply to distributions made after December 31, 2016.

SEC. 112. REPEAL OF 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, 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 apply to calendar years beginning after December 31, 2016, and ending before January 1, 2021.”

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:

“(i) REPEAL.—This section shall apply to sales or services performed after December 31, 2016.”

SEC. 115. REPEAL OF HEALTH INSURANCE TAX.

Subtitle A of chapter 2A of title 26 is amended by striking “Such tax” and inserting “The tax imposed by the preceding subsection,”.

SEC. 116. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSESALLOCABLE TO MEDICARE PART D SUBSIDY.

(a) In General.—Subsection (a) of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: “This section shall not be taken into account for purposes of determining whether any deduction is allowable with respect to any cost taken into account in determining such payment.”.

(b) Effective Date.—The amendment made by this section shall apply to taxable years beginning after December 31, 2016.
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 services provided by Federally certified opioid treatment programs, and overdose prevention programs.

The purposes of the Judiciary is authorized to meet during the session of the Senate on Tuesday, July 25, 2017, at 10 a.m., in room SD-226 of the Dirksen Senate Office Building, to conduct a hearing entitled “Nominations.”

COMMITTEE ON INTELLIGENCE

The Senate Select Committee on Intelligence is authorized to meet during the session of the 115th Congress of the U.S. Senate on Tuesday, July 25, 2017 from 2:30 pm, in room SH-219 of the Senate Hart Office Building to hold a Closed Business Meeting followed by a Closed Member Briefing.

SUBCOMMITTEE ON SEAPOWER

The Subcommittee on Seapower of the Committee on Armed Services is authorized to meet during the session of the Senate on Tuesday, July 25, 2017, at 2:30 p.m., in open session, to receive testimony on options and considerations for achieving a 355-ship Navy from naval analysts.

SUBCOMMITTEE ON OCEAN, ATMOSPHERE, FISHERIES, AND COAST GUARD

The Committee on Commerce, Science, and Transportation is authorized to meet during the session of the Senate on Tuesday, July 25, 2017, at 10 AM in room 253 of the Russell Senate Office Building. The Committee will hold Subcommittee Hearing on “Efforts on Marine Debris in the Oceans and Great Lakes.”

SUBCOMMITTEE ON CLIMATE AND NUCLEAR SAFETY

The Subcommittee on Clean and Nuclear Safety of the Committee on Environment and Public Works be authorized to meet during the session of the Senate on Tuesday, July 25, 2017, at 10 AM, in Room 406 of the Dirksen Senate office building, to conduct a hearing entitled, “Developing and Deploying Advanced Clean Energy Technologies.”

SUBCOMMITTEE ON EAST ASIA, THE PACIFIC, AND INTERNATIONAL CYBER SECURITY POLICY

The Committee on Foreign Relations Subcommittee on East Asia, the Pacific, and International Cyber Security Policy is authorized to meet during the session of the Senate on Tuesday, July 25, 2017 at 2:30 p.m., to hold a 1 hearing entitled “Assessing the Maximum Pressure and Engagement Policy toward North Korea.”

PRIVILEGES OF THE FLOOR

Mr. ENZI. Mr. President, I ask unanimous consent that Paul Vinovich and Greg D’Angelo, from my staff, be given access floor passes to the Senate floor and the Robert Creager, Tiffany Mortimore, Sam Ross, and Sam Safari, interns for the Budget Committee, be granted floor privileges during the consideration of H.R. 1628.

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

ORDERS FOR WEDNESDAY, JULY 26, 2017

Mr. ENZI. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:30 a.m., Wednesday, July 26; that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for later in the day, and morning business be closed; further, that following leader remarks, the Senate resume consideration of H.R. 1628, with the time until 11:30 a.m. equally divided between the two leaders or their designees; finally, that the previous order with respect to the vote time in relation to amendment No. 271 be modified to occur at 11:30 a.m. tomorrow, and the vote on the pending motion to come occur at 3:30 p.m. tomorrow. With all other provisions remaining in effect.

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

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. ENZI. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that it stand adjourned under the previous order.

There being no objection, the Senate, at 9:58 p.m., adjourned until Wednesday, July 26, 2017, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF AGRICULTURE

SAMUEL H. CLODNER, JR., OF IOWA, TO BE UNDER SECRETARY OF AGRICULTURE FOR RESEARCH, EDUCATION, AND ECONOMICS, VICE CATHRINE E. WOTKI.

DEPARTMENT OF DEFENSE

MARK T. ENZI, OF VIRGINIA, TO BE SECRETARY OF THE NAVY, VICE ERIC K. FANNING.

ANTHONY KURTA, OF MONTANA, TO BE A PRINCIPAL DEPUTY UNDER SECRETARY OF DEFENSE, VICE LAURA JUNOR, RESIGNED.

ROBERT L. WILKIE, OF NORTH CAROLINA, TO BE UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, VICE JESSICA GARCIA-SOFREN, RESIGNED.

DEPARTMENT OF INDIAN AFFAIRS

JOSEPH B. BUSH, OF ALASKA, TO BE AN ASSISTANT SECRETARY OF THE INTERIOR, VICE JANICE MARION SCHNEIDER.

DEPARTMENT OF STATE

KATHLEEN M. FITZPATRICK, OF THE DISTRICT OF COLUMBIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND plenipotentiary of the UNITED STATES OF AMERICA TO THE DEMOCRATIC REPUBLIC OF TIMOR-LESTE.

A. WESS MITCHELL, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF STATE FOR EUGENES, VICE VICTORIA NULAND.

DEPARTMENT OF HOMELAND SECURITY

DANIEL ALAN CROLL, OF MARYLAND, TO BE DEPUTY ADMINISTRATOR, FEDERAL EMERGENCY MANAGEMENT AGENCY, DEPARTMENT OF HOMELAND SECURITY, VICE JOSEPH L. VDAMME.

IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHERE NOT OTHERWISE DESIGNATED, HAS BEEN ASSIGNED TO A POST OF RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601: