AMENDMENT NO._____ Calendar No._____

Purpose: In the nature of a substitute.

IN THE SENATE OF THE UNITED STATES—115th Cong., 1st Sess.

H. R. 1628

To provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017.

Referred to the Committee on _____ and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT IN THE NATURE OF A SUBSTITUTE intended to be proposed by _____

Viz:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Better Care Reconciliation Act of 2017''.

TITLE I

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

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

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

SEC. 102. RESTRICTIONS FOR THE PREMIUM TAX CREDIT.

(a) ELIGIBILITY FOR CREDIT.—

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

(A) by striking ''equals or exceeds 100 percent but does not exceed 400 percent'' in subparagraph (A) and inserting ''does not exceed 350 percent'', and

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

(2) TREATMENT OF CERTAIN ALIENS.—

(A) IN GENERAL.—Paragraph (2) of section 36B(e) 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 1411(a)(1) of the Patient Protection and Affordable Care Act is amended by striking ''or an alien lawfully present in the United States'' and inserting ''or a qualified alien (within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996)''.

(ii) Section 1411(c)(2)(B) of such Act is amended by striking ''an alien lawfully present in the United States'' each place it appears in clauses (i)(I) and (ii)(II) and inserting ''a qualified alien (within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996)''.

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

(I) by striking ''not lawfully present in the United States'' and inserting ''not citizens or nationals of the United States or qualified aliens (within the meaning of section 431 of the Personal Responsibility and Work

Opportunity Reconciliation Act of 1996)'', and

(II) by striking ''INDIVIDUALS NOT LAWFULLY PRESENT'' in the heading and inserting ''CERTAIN ALIENS''.

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

(1) USE OF BENCHMARK PLAN.—

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

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

(ii) by striking ''such silver plan'' in paragraph (3)(C) and inserting ''such benchmark plan'', and

(iii) in paragraph (3)(B)—

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

''(B) APPLICABLE MEDIAN COST BENCHMARK PLAN.—The applicable median cost benchmark plan with respect to any applicable taxpayer is the qualified health plan offered in the individual market in the rating area in which the taxpayer resides which—

''(i) provides a level of coverage that is designed to provide benefits that are actuarially equivalent to 58 percent of the full actuarial value of the benefits (as determined under rules similar to the rules of paragraphs (2) and (3) of section 1302(d) of the Patient Protection and Affordable Care Act) provided under the plan,

''(ii) has a premium which is the median premium of all qualified health plans described in clause (i) which are offered in the individual market in such rating area (or, in any case in which no such plan has such median premium, 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 (iv)(I)''.

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

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

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

"In the case of household income (expressed as a percent of the poverty line) within the following income tier:	Up to Age 29		Age 30-39		Age 40-49		Age 50-59		Over Age 59	
	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %
Up to 100%	2	2	2	2	2	2	2	2	2	2
100%-133%	2	2.5	2	2.5	2	2.5	2	2.5	2	2.5
133%-150%	2.5	4	2.5	4	2.5	4	2.5	4	2.5	4
150%-200%	4	4.3	4	5.3	4	6.3	4	7.3	4	8.3
200%-250%	4.3	4.3	5.3	5.9	6.3	8.05	7.3	9	8.3	10
250%-300%	4.3	4.3	5.9	5.9	8.05	8.35	9	10.5	10	11.5
300%-350%	4.3	6.4	5.9	8.9	8.35	12.5	10.5	15.8	11.5	16.2",

(B) by striking "0.504" in clause (ii)(III) and inserting "0.4", and

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

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

(c) 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 AR-

RANGEMENTS.—Section 36B(c)(4) of such Code is amended—

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

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

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

(1) IN GENERAL.—Section 36B(c)(3)(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, 2017.

(e) ALLOWANCE OF CREDIT FOR CATASTROPHIC PLANS.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986, as amended by this Act, is amended by striking '', except that such term shall not include a quali-

fied health plan that is a catastrophic plan described in section 1302(e) of such Act''.

(f) INCREASED PENALTY ON ERRONEOUS CLAIMS OF CREDIT.—Section 6676(a) of the Internal Revenue Code of 1986 is amended by inserting ''(25 percent in the case of a claim for refund or credit relating to the health insurance coverage credit under section 36B)'' after ''20 percent''.

(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 45R of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

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

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

(b) DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT FOR PLAN WHICH DOES NOT INCLUDE PROTECTIONS FOR LIFE.—

(1) IN GENERAL.—Subsection (h) of section 45R of the Internal Revenue Code of 1986 is amended—

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

''(1) IN GENERAL.—Any term'', and

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

''(2) EXCLUSION OF CERTAIN HEALTH PLANS.—The term 'qualified health plan' does not include any health plan that includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).''.

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

SEC. 104. INDIVIDUAL MANDATE.

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

(1) in paragraph (2)(B)(iii), by striking ''2.5 percent'' and inserting ''Zero percent'', and

(2) in paragraph (3)—

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

(B) by striking subparagraph (D).

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

SEC. 105. EMPLOYER MANDATE.

(a) IN GENERAL.—

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

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

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

SEC. 106. STATE STABILITY AND INNOVATION PROGRAM.

(a) IN GENERAL.—Section 2105 of the Social Security Act (42 U.S.C. 1397ee) is amended by adding at the end the following new subsections:

''(h) SHORT-TERM ASSISTANCE TO ADDRESS COVERAGE AND ACCESS DISRUPTION AND PROVIDE SUPPORT FOR STATES.—

''(1) APPROPRIATION.—There are authorized to be appropriated, and are appropriated, out of monies in the Treasury not otherwise obligated, $15,000,000,000 for each of calendar years 2018 and 2019, and $10,000,000,000 for each of calendar years 2020 and 2021, to the Administrator of the Centers for Medicare & Medicaid Services (in this subsection and subsection (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 no-

tice of intent to participate in the program established under this subsection.

"(B) NOTICE OF INTENT TO PARTICIPATE.—To be eligible for funding under this subsection, a health insurance issuer shall submit to the Administrator a notice of intent to participate at such time (but, in the case of funding for calendar year 2018, not later than 35 days after the date of enactment of this subsection and, in the case of funding for calendar year 2019, 2020, 2021, 2022, 2023, 2024, 2025, or 2026, not later than March 31 of the previous year) and in such form and manner as specified by the Administrator and containing—

"(i) a certification that the health insurance issuer will use the funds in accordance with the requirements of paragraph (5); and

"(ii) such information as the Administrator may require to carry out this subsection.

"(3) PROCEDURE FOR DISTRIBUTION OF FUNDS.—The Administrator shall determine an appropriate procedure for providing and distributing funds under this subsection that includes reserving

an amount equal to 1 percent of the amounts appropriated under paragraph (1) for a calendar year for providing and distributing funds to health insurance issuers in States where the cost of insurance premiums are at least 75 percent higher than the national average.

''(4) NO MATCH.—Neither the State percentage applicable to payments to States under subsection (i)(5)(B) nor any other matching requirement shall apply to funds provided to health insurance issuers under this subsection.

''(5) USE OF FUNDS.—Funds provided to a health insurance issuer under paragraph (1) or (6) shall be subject to the requirements of paragraphs (1)(D) and (7) of subsection (i) in the same manner as such requirements apply to States receiving payments under subsection (i) and shall be used only for the activities specified in paragraph (1)(A)(ii) of subsection (i).

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

''(A) APPROPRIATION.—In addition to the amounts appropriated under paragraph (1), there is appropriated, out of any money in the

Treasury not otherwise obligated, $10,000,000,000 for each of calendar years 2020 through 2026, for the purpose of funding arrangements with health insurance issuers to support the offering of 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 the Better Care Reconciliation Act, to assist such health insurance issuers in covering high risk individuals enrolled in qualified health plans through an Exchange in rating areas in which coverage is offered in accordance with section 212(a) of such Act. The Administrator shall determine an appropriate procedure for making such payments.

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

"(I) based on the percentage of rating areas in the State that meet the conditions in section212(b) of such Act; and

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

"(i) LONG-TERM STATE STABILITY AND INNOVATION PROGRAM.—

"(1) APPLICATION AND CERTIFICATION REQUIREMENTS.—To be eligible for an allotment of funds 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 the following:

"(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 have or 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 offered through an employer, enroll in health insurance coverage under a plan offered in the individual market (within the meaning of section 5000A(f)(1)(C) of the Internal Revenue Code of 1986).

"(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 offered in the individual market (within the meaning of section

5000A(f)(1)(C) 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, and 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).

''(B) A certification that the State shall 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 the funds provided under this subsection shall only be used for the activities specified in subparagraph (A).

''(D) 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 and payments under this subsection and all references in this subsection to 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 not otherwise appropriated—

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

"(ii) for calendar year 2020, $29,000,000,000;

"(iii) for 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) ALLOTMENTS.—

"(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 spending requirements in paragraphs (6) are met for the year and that reserves an amount that is at least 1 percent of the amount appropriated under subparagraph (A) 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 such year under subparagraph (A), such amount as specified by the Administrator with respect to the State and application and year.

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

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

''(aa) determine the amount of funds, if any, remaining un-

used under subparagraph (A) from the previous year; and

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

''(II) APPLICABLE STATE PERCENTAGE.—The State percentage specified for a year in paragraph (5)(B)(ii) shall apply to funds redistributed under subclause (I) in that year.

''(C) AVAILABILITY OF ALLOTTED STATE FUNDS.—

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

"(ii) AVAILABILITY OF AMOUNTS REDISTRIBUTED.—Amounts redistributed to a State under subparagraph (B)(ii) in a year shall be available for expenditure by the State through the end of the second succeeding year.

"(5) PAYMENTS.—

"(A) ANNUAL PAYMENT OF ALLOTMENTS.—Subject to subparagraph (B), the Administrator shall pay to each State that has an application approved under this subsection for a year, from the allotment determined under paragraph (4)(B) for the State for the year, an amount equal to the Federal percentage of the State's expenditures for the year.

"(B) STATE EXPENDITURES REQUIRED BEGINNING 2022.—For purposes of subparagraph (A), the Federal percentage is equal to 100 percent reduced by the State percentage for that year, and the State percentage is equal to—

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

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

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

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

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

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

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

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

"(C) 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 State and such other investigation as the Administrator shall find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior years.

''(ii) MISUSE OF FUNDS.—If the Administrator determines that a State is not using funds paid to the State under this subsection in a manner consistent with the description provided by the State in its application approved under paragraph (1), the Administrator may withhold payments, reduce payments, or recover previous payments to the State under this subsection as the Administrator deems appropriate.

''(D) FLEXIBILITY IN SUBMITTAL OF CLAIMS.—Nothing in this subsection shall be construed as preventing a State from claiming as expenditures in the year expenditures that were incurred in a previous year.

''(6) REQUIRED USES.—

''(A) PREMIUM STABILIZATION AND INCENTIVES FOR INDIVIDUAL MARKET PARTICIPATION.—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 2026, the Administrator shall ensure that at least $15,000,000,000 of the amounts appropriated for each of calendar years 2020 and 2021 under paragraph (4)(A), and at least $14,000,000,000 of the amounts appropriated for each of calendar years 2022 through 2026 under such paragraph, are used by States for the purposes described in paragraph (1)(A)(iv) and in accordance with guidance issued by the Administrator not later than September 1, 2019, that specifies the parameters for the use of funds for such purposes.

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

(b) OTHER TITLE XXI AMENDMENTS.—

(1) Section 2101 of such Act (42 U.S.C. 1397aa) is amended—

(A) in subsection (a), in the matter preceding paragraph (1), by striking ''The purpose'' and inserting ''Except with respect to short-term assistance activities under section 2105(h) and the Long-Term State Stability and Innovation Program established in section 2105(i), the purpose''; and

(B) in subsection (b), in the matter preceding paragraph (1), by inserting ''subsection (a) or (g) of'' before ''section 2105''.

(2) Section 2105(c)(1) of such Act (42 U.S.C. 1397ee(c)(1)) is amended by striking ''and may not include'' and inserting ''or to carry out short-term assistance activities under subsection (h) or the Long-Term State Stability and Innovation Program established in subsection (i) and, except in the case of funds made available under subsection (h) or (i), may not include''.

(3) Section 2106(a)(1) of such Act (42 U.S.C. 1397ff(a)(1)) is amended by inserting ''subsection (a) or (g) of'' before ''section 2105''.

SEC. 107. BETTER CARE RECONCILIATION IMPLEMENTATION FUND.

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

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

SEC. 108. REPEAL OF THE TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS.

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

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

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

SEC. 109. REPEAL OF TAX ON OVER-THE-COUNTER MEDICATIONS.

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

(b) Archer MSAs.—Subparagraph (A) of section 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 expenses incurred with respect to taxable years beginning after December 31, 2016.

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

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

(b) ARCHER MSAS.—Section 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. 111. 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. 112. 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. 113. REPEAL OF MEDICAL DEVICE EXCISE TAX.

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

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

SEC. 114. 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. 115. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.

(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: ''This section shall not be taken into account for purposes of determining whether any deduction is allowable with respect to any cost taken into account in determining such payment.''.

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

SEC. 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 TANNING TAX.

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

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services performed after September 30, 2017.

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

(a) PURCHASE OF HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Paragraph (2) of section 223(d) of the Internal Revenue Code of 1986, as amended by section 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'' in subparagraph (A) and inserting ''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)(iii), by striking the period at the end of subparagraph (C)(iv) and inserting '', or'', 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,

''(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(l).''.

(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 223(d)(2)(C) of the Internal Revenue Code of 1986, as amended by subsection (a) and section 122, is amended—

(A) by striking ''or'' at the end of clause (iv), by striking the period at the end of clause (v), and by adding at the end the following:

''(vi) any plan which—

''(I) is offered by a health insurance issuer which meets the conditions described in section 212(b) of the Better Care Reconciliation Act of 2017 for the plan year, and

''(II) would not be permitted to be offered in the market but for such section.'', and

(B) by inserting ''or (vi)'' after ''clause (v)'' in the last sentence thereof.

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

SEC. 119. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAVINGS ACCOUNT INCREASED TO AMOUNT OF DEDUCTIBLE AND OUT-OF-POCKET LIMITATION.

(a) SELF-ONLY COVERAGE.—Section 223(b)(2)(A) of the Internal Revenue Code of 1986 is amended by striking ''$2,250'' and inserting ''the amount in effect under subsection (c)(2)(A)(ii)(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)(II)''.

(c) COST-OF-LIVING ADJUSTMENT.—Section 223(g)(1) of such Code is amended—

(1) by striking ''subsections (b)(2) and'' both places it appears and inserting ''subsection'', and

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

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

SEC. 120. ALLOW BOTH SPOUSES TO MAKE CATCH-UP 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 of either spouse (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 division between the spouses.".

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

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

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

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

(b) EFFECTIVE DATE.—The amendment made by this 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 adding 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.—Notwithstanding section 504(a), 1902(a)(23), 1903(a), 2002, 2005(a)(4), 2102(a)(7), or 2105(a)(1) of the Social Security Act (42 U.S.C. 704(a), 1396a(a)(23), 1396b(a), 1397a, 1397d(a)(4), 1397bb(a)(7), 1397ee(a)(1)), or the terms of any Medicaid waiver in effect on the date of enactment of this Act that is approved under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n), for the 1-year period beginning on the date of enactment of this Act, no

Federal funds provided from a program referred to in this subsection that is considered direct spending for any year may be made available to a State for payments to a prohibited entity, whether made directly to the prohibited entity or through a managed care organization under contract with the State.

(b) DEFINITIONS.—In this section:

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

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

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

(ii) is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in family planning services, reproductive health, and related medical care; and

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

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

(II) in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, 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 program under title XIX of the Social Security Act in fiscal year 2014 made directly to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $350,000,000.

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

SEC. 124. MEDICAID PROVISIONS.

The Social Security Act is amended—

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

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

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

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)(A)—

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

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

''(XXIII) beginning January 1, 2020, who are expansion enrollees (as defined in subsection (nn)(1));''; and

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

''(nn) EXPANSION ENROLLEES.—

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

''(A) who is under 65 years of age;

''(B) who is not pregnant;

''(C) who is not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII;

''(D) who is not described in any of subclauses (I) through (VII) of subsection (a)(10)(A)(i); and

''(E) whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved.

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

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

(A) in subsection (y)(1)—

(i) in the matter preceding subparagraph (A), by striking '', with respect to'' and all that follows through ''shall be equal to'' and inserting ''and that has elected to cover newly eligible individuals before March 1, 2017, with respect to amounts expended by such State before January 1, 2020, for medical assistance for newly eligible individuals 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 deter-

mined for the State and year under subsection (b) (without regard to this subsection) and'';

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

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

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

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

''(G) 80 percent for calendar quarters in 2022; 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 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 2023, and, in the case of any other State, for calendar quarters (or portions of calendar quarters) after February 28, 2017.''; and

(B) in subsection (z)(2)—

(i) in subparagraph (A)—

(I) by inserting ''through 2023'' after ''each year thereafter''; and

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

(ii) in subparagraph (B)(ii)—

(I) in subclause (III), by adding ''and'' at the end; and

(II) by striking subclauses (IV), (V), and (VI) and inserting the following new subclause:

''(IV) 2017 and each subsequent year through 2023 is 80 percent.''.

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

SEC. 126. RESTORING FAIRNESS IN DSH ALLOTMENTS.

Section 1923(f)(7) of the Social Security Act (42 U.S.C. 1396r–4(f)(7)) is amended by adding at the end the following new subparagraph:

''(C) NON-EXPANSION STATES.—

''(i) IN GENERAL.—In the case of a State that is a non-expansion State for a fiscal year—

''(I) subparagraph (A) shall not apply to the DSH allotment for such State and fiscal year; and

''(II) the DSH allotment for the State for fiscal year 2020 (including for a non-expansion State that has a DSH allotment determined under paragraph (6)) shall be increased by the amount calculated according to clause (iii).

''(ii) NO CHANGE IN REDUCTION FOR EXPANSION STATES.—In the case of a

State that is an expansion State for a fiscal year, the DSH allotment for such State and fiscal year shall be determined as if clause (i) did not apply.

''(iii) AMOUNT CALCULATED.—For purposes of clause (i)(II), the amount calculated according to this clause for a non-expansion State is the following:

''(I) For each State, the Secretary shall calculate a ratio equal to the State's fiscal year 2016 DSH allotment divided by the number of uninsured individuals in the State for such fiscal year (determined on the basis of the most recent information available from the Bureau of the Census).

''(II) The Secretary shall identify the States whose ratio as so determined is below the national average of such ratio for all States.

''(III) The amount calculated pursuant to this clause is an amount that, if added to the State's fiscal year 2016 DSH allotment, would in-

crease the ratio calculated pursuant to subclause (I) up to the national average for all States.

''(iv) DISREGARD OF INCREASE.—The DSH allotment for a non-expansion State for the second, third, and fourth quarters of fiscal year 2024 and 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 (i)(II).

''(v) NON-EXPANSION AND EXPANSION STATE DEFINED.—In this subparagraph:

''(I) The term 'expansion State' means with respect to a fiscal year, a State that, on or after January 1, 2021, provides eligibility under subclause (XXIII) of section 1902(a)(10)(A)(ii) for medical assistance under this title (or provides eligibility for individuals described in such subclause under a waiver of the State plan approved under section 1115).

''(II) The term 'non-expansion State' means, with respect to a fiscal

year, a State that is not an expansion State, except that—

"(aa) in the case of a State that provides eligibility under clause (i)(VIII), (ii)(XX), or (ii)(XXIII) of section 1902(a)(10)(A) for medical assistance under this title (or provides eligibility for individuals described in any of such clauses under a waiver of the State plan approved under section 1115) for any quarter occurring during the period that begins on October 1, 2017, and ends on December 31, 2020 the State shall be treated as a non-expansion State for purposes of clause (i) only for quarters beginning on or after the first day of the first month for which the State no longer provides such eligibility; and

"(bb) in the case of a State identified by the Secretary under clause (iii)(II) that is a non-ex-

pansion State on January 1, 2021, but which provided such eligibility on January 1, 2020, the DSH allotment for such State for each of fiscal years 2021 through 2023 and the first fiscal quarter of 2024 shall be determined as if the State's DSH allotment for fiscal year 2020 had been increased under clause (i)(II).''.

SEC. 127. REDUCING STATE MEDICAID COSTS.

(a) IN GENERAL.—

(1) STATE PLAN REQUIREMENTS.—Section 1902(a)(34) of the Social Security Act (42 U.S.C. 1396a(a)(34)) is amended by striking ''in or after the third month'' and all that follows through ''individual)'' and inserting ''in or after the month in which the individual (or, in the case of a deceased individual, another individual acting on the individual's behalf) made application (or, in the case of an individual who is 65 years of age or older or who is eligible for medical assistance under the plan on the basis of being blind or disabled, in or after the third month before such month)''.

(2) DEFINITION OF MEDICAL ASSISTANCE.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by striking ''in or after the third month before the month in which the recipient makes application for assistance'' and inserting ''in or after the month in which the recipient makes application for assistance, or, in the case of a recipient who is 65 years of age or older or who is eligible for medical assistance on the basis of being blind or disabled at the time application is made, in or after the third month before the month in which the recipient makes application for assistance,''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to medical assistance with respect to individuals whose eligibility for such assistance is based on an application for such assistance made (or deemed to be made) on or after October 1, 2017.

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. 1396r–4) the following new section:

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

''SEC. 1923A. (a) IN GENERAL.—Subject to the limitations of this section, for each year during the period beginning with fiscal year 2018 and ending with fiscal year 2022, each State that is one of the 50 States or the District of Columbia and that, as of July 1 of the preceding fiscal year, did not provide for eligibility under clause (i)(VIII), (ii)(XX), or (ii)(XXIII) of section 1902(a)(10)(A) for medical assistance under this title (or a waiver of the State plan approved under section 1115) (each such State or District referred to in this section for the fiscal year as a 'non-expansion State') may adjust the payment amounts otherwise provided under the State plan under this title (or a waiver of such plan) to health care providers that provide health care services to individuals enrolled under this title (in this section referred to as 'eligible providers') so long as the payment adjustment to such an eligible provider does not exceed the provider's costs in furnishing health care services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) to individuals who either are eligible for medical assistance under the State plan (or under a waiver of such plan) or

have no health insurance or health plan coverage for such services.

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

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

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

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

''(1) the population of the State with income below 138 percent of the poverty line in 2015 (as determined based the table entitled 'Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age' for the universe of the civilian noninstitutionalized population for whom poverty status is determined based

on the 2015 American Community Survey 1–Year Estimates, as published by the Bureau of the Census), to

''(2) the sum of the populations under paragraph (1) for all non-expansion States.

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

SEC. 129. ELIGIBILITY REDETERMINATIONS.

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

''(J) FREQUENCY OF ELIGIBILITY REDETERMINATIONS.—Beginning on October 1, 2017, and notwithstanding subparagraph (H), in the case of 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 (ii)(XXIII) of subsection (a)(10)(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 elect).''.

(b) INCREASED ADMINISTRATIVE MATCHING PERCENTAGE.—For each calendar quarter during the period beginning on October 1, 2017, and ending on December 31, 2019, the Federal matching percentage otherwise applicable under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) with respect to State expenditures during such quarter that are attributable to meeting the requirement of section 1902(e)(14) (relating to determinations of eligibility using modified adjusted gross income) of such Act shall be increased by 5 percentage points with respect to State expenditures attributable to activities carried out by the State (and approved by the Secretary) to exercise the option described in subparagraph (J) of such section (relating to eligibility redeterminations made on a 6-month or shorter basis) (as added by subsection (a)) to increase the frequency of eligibility redeterminations.

SEC. 130. OPTIONAL WORK REQUIREMENT FOR NONDISABLED, NONELDERLY, NONPREGNANT INDIVIDUALS.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as previously amended, is further amended by adding at the end the following new subsection:

''(oo) OPTIONAL WORK REQUIREMENT FOR NONDISABLED, NONELDERLY, NONPREGNANT INDIVIDUALS.—

''(1) IN GENERAL.—Beginning October 1, 2017, subject to paragraph (3), a State may elect to condition medical assistance to a nondisabled, nonelderly, nonpregnant individual under this title upon such an individual's satisfaction of a work requirement (as defined in paragraph (2)).

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

''(3) REQUIRED EXCEPTIONS.—States administering a work requirement under this subsection may not apply such requirement to—

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

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

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

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

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

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

(b) INCREASE IN MATCHING RATE FOR IMPLEMENTATION.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following:

"(aa) The Federal matching percentage otherwise applicable under subsection (a) with respect to State administrative expenditures during a calendar quarter for which

the State receives payment under such subsection shall, in addition to any other increase to such Federal matching percentage, be increased for such calendar quarter by 5 percentage points with respect to State expenditures attributable to activities carried out by the State (and approved by the Secretary) to implement subsection (oo) of section 1902.''.

SEC. 131. PROVIDER TAXES.

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

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

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

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

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

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

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

SEC. 132. PER CAPITA ALLOTMENT FOR MEDICAL ASSISTANCE.

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

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

(A) in subsection (a), in the matter before paragraph (1), by inserting "and section 1903A(a)" after "except as otherwise provided in this section"; and

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

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

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

"(a) APPLICATION OF PER CAPITA CAP ON PAYMENTS FOR MEDICAL ASSISTANCE EXPENDITURES.—

"(1) IN GENERAL.—If a State which is one of the 50 States or the District of Columbia has excess aggregate medical assistance expenditures (as defined in paragraph (2)) for a fiscal year (beginning with fiscal year 2020), the amount of payment to the State under section 1903(a)(1) for each quarter in the following fiscal year shall be reduced by ¼ of the excess aggregate medical assistance payments (as defined in paragraph (3)) for that previous fiscal year. In this section, the term 'State' means only the 50 States and the District of Columbia.

"(2) EXCESS AGGREGATE MEDICAL ASSISTANCE EXPENDITURES.—In this subsection, the term 'excess aggregate medical assistance expenditures' means, for a State for a fiscal year, the amount (if any) by which—

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

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

"(3) EXCESS AGGREGATE MEDICAL ASSISTANCE PAYMENTS.—In this subsection, the term 'excess aggregate medical assistance payments' means, for a State for a fiscal year, the product of—

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

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

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

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

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

''(5) PER CAPITA BASE PERIOD.—

''(A) IN GENERAL.—In this section, the term 'per capita base period' means, with respect to a State, a period of 8 (or, in the case of a State selecting a period under subparagraph (D), not less than 4) consecutive fiscal quarters selected by the State.

''(B) TIMELINE.—Each State shall submit its selection of a per capita base period to the Secretary not later than January 1, 2018.

''(C) PARAMETERS.—In selecting a per capita base period under this paragraph, a State shall—

''(i) only select a period of 8 (or, in the case of a State selecting a base period under subparagraph (D), not less than 4) consecutive fiscal quarters for which all the data necessary to make determinations required under this section is available, as determined by the Secretary; and

''(ii) shall not select any period of 8 (or, in the case of a State selecting a base period under subparagraph (D), not less than 4) consecutive fiscal quarters that begins with a fiscal quarter earlier than the

first quarter of fiscal year 2014 or ends with a fiscal quarter later than the third fiscal quarter of 2017.

"(D) BASE PERIOD FOR LATE-EXPANDING STATES.—

"(i) IN GENERAL.—In the case of a State that did not provide for medical assistance for the 1903A enrollee category described in subsection (e)(2)(D) as of the first day of the fourth fiscal quarter of fiscal year 2015 but which provided for such assistance for such category in a subsequent fiscal quarter that is not later than the fourth quarter of fiscal year 2016, the State may select a per capita base period that is less than 8 consecutive fiscal quarters, but in no case shall the period selected be less than 4 consecutive fiscal quarters.

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

to a per capita base period selected under this subparagraph.

"(iii) APPLICATION OF BASE PERIOD ADJUSTMENTS.—The adjustments to amounts for per capita base periods required under subsections (b)(5) and (d)(4)(E) shall be applied to amounts for per capita base periods selected under this subparagraph by substituting 'divided by the ratio that the number of quarters in the base period bears to 4' for 'divided by 2'.

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

"(b) ADJUSTED TOTAL MEDICAL ASSISTANCE EXPENDITURES.—Subject to subsection (g), the following shall apply:

"(1) IN GENERAL.—In this section, the term 'adjusted total medical assistance expenditures' means, for a State—

"(A) for the State's per capita base period (as defined in subsection (a)(5)), the product of—

"(i) the amount of the medical assistance expenditures (as defined in paragraph (2) and adjusted under paragraph (5)) for the State and period, reduced by the amount of any excluded expenditures (as defined in paragraph (3) and adjusted under paragraph (5)) for the State and period otherwise included in such medical assistance expenditures; and

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

"(B) for fiscal year 2019 or a subsequent fiscal year, the amount of the medical assistance expenditures (as defined in paragraph (2)) for the State and fiscal year that is attributable

to 1903A enrollees, reduced by the amount of any excluded expenditures (as defined in paragraph (3)) for the State and fiscal year otherwise included in such medical assistance expenditures and includes non-DSH supplemental payments (as defined in subsection (d)(4)(A)(ii)) and payments described in subsection (d)(4)(A)(iii) but shall not be construed as including any expenditures attributable to the program under section 1928 (relating to State pediatric vaccine distribution programs). In applying subparagraph (B), non-DSH supplemental payments (as defined in subsection (d)(4)(A)(ii)) and payments described in subsection (d)(4)(A)(iii) shall be treated as fully attributable to 1903A enrollees.

''(2) MEDICAL ASSISTANCE EXPENDITURES.—In this section, the term 'medical assistance expenditures' means, for a State and fiscal year or per capita base period, the medical assistance payments as reported by medical service category on the Form CMS-64 quarterly expense report (or successor to such a report form, and including enrollment data and subsequent adjustments to any such report, in this section referred to collectively as a 'CMS-64 re-

port') for quarters in the year or base period for which payment is (or may otherwise be) made pursuant to section 1903(a)(1), adjusted, in the case of a per capita base period, under paragraph (5).

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

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

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

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

''(D) EXPENDITURES FOR PUBLIC HEALTH EMERGENCIES.—Any expenditures that are subject to a public health emergency exclusion under paragraph (6).

"(4) 1903A BASE PERIOD POPULATION PERCENTAGE.—In this subsection, the term '1903A base period population percentage' means, for a State, the Secretary's calculation of the percentage of the 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)).

"(5) ADJUSTMENTS FOR PER CAPITA BASE PERIOD.—In calculating medical assistance expenditures under paragraph (2) and excluded expenditures under paragraph (3) for a State for the State's per capita base period, the total amount of each type of expenditure for the State and base period shall be divided by 2.

"(6) AUTHORITY TO EXCLUDE STATE EXPENDITURES FROM CAPS DURING PUBLIC HEALTH EMERGENCY.—

"(A) IN GENERAL.—During the period that begins on January 1, 2020, and ends on December 31, 2024, the Secretary may exclude, from a State's medical assistance expenditures for a fiscal year or portion of a fiscal year that occurs during such period, an amount that shall

not exceed the amount determined under subparagraph (B) for the State and year or portion of a year if—

"(i) a public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act existed within the State during such year or portion of a year; and

"(ii) the Secretary determines that such an exemption would be appropriate.

"(B) MAXIMUM AMOUNT OF ADJUSTMENT.—The amount excluded for a State and fiscal year or portion of a fiscal year under this paragraph shall not exceed the amount by which—

"(i) the amount of State expenditures for medical assistance for 1903A enrollees in areas of the State which are subject to a declaration described in subparagraph (A)(i) for the fiscal year or portion of a fiscal year; exceeds

"(ii) the amount of such expenditures for such enrollees in such areas during the most recent fiscal year or portion of a fiscal year of equal length to the portion of

a fiscal year involved during which no such declaration was in effect.

"(C) AGGREGATE LIMITATION ON EXCLUSIONS AND ADDITIONAL BLOCK GRANT 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 $5,000,000,000.

"(D) REVIEW.—If the Secretary exercises the authority under this paragraph with respect to a State for a fiscal year or portion of a fiscal year, the Secretary shall, not later than 6 months after the declaration described in subparagraph (A)(i) ceases to be in effect, conduct an audit of the State's medical assistance expenditures for 1903A enrollees during the year or portion of a year to ensure that all of the expenditures so excluded were made for the purpose of ensuring that the health care needs of 1903A enrollees in areas affected by a public health emergency are met.

"(c) TARGET TOTAL MEDICAL ASSISTANCE EXPENDITURES.—

"(1) CALCULATION.—In this section, the term 'target total medical assistance expenditures' means, for a State for a fiscal year and subject to paragraph (4), the sum of the products, for each of the 1903A enrollee categories (as defined in subsection (e)(2)), of—

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

"(B) the number of 1903A enrollees for such enrollee category, State, and fiscal year, as determined under subsection (e)(4).

"(2) TARGET PER CAPITA MEDICAL ASSISTANCE EXPENDITURES.—In this subsection, the term 'target per capita medical assistance expenditures' means, for a 1903A enrollee category and State—

"(A) for fiscal year 2020, an amount equal to—

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

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

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

"(i) the target per capita medical assistance expenditures (under subparagraph (A) or this subparagraph) for the 1903A enrollee category and State for the preceding fiscal year; increased by

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

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

"(A) for fiscal years before 2025—

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

"(ii) for each of the 1903A enrollee categories described in subparagraphs (A) and (B) of subsection (e)(2), the percentage increase described in clause (i) plus 1 percentage point; and

"(B) for fiscal years after 2024, for all 1903A enrollee categories, the percentage increase in the consumer price index for all urban consumers (U.S. city average) from September of the previous fiscal year to September of the fiscal year involved.

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

"(A) IN GENERAL.—In the case of a State that had a DSH allotment under section 1923(f) for fiscal year 2016 that was more than 6 times the national average of such allotments for all the States for such fiscal year and that requires political subdivisions within the State to contribute funds towards medical assistance or other expenditures under the State plan under this title (or under a waiver of such plan) for a fiscal year (beginning with fiscal year 2020), the target total medical assistance ex-

penditures for such State and fiscal year shall be decreased by the amount that political subdivisions in the State are required to contribute under the plan (or waiver) without reimbursement from the State for such fiscal year, other than contributions described in subparagraph (B).

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

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

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

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

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

"(5) ADJUSTMENTS TO STATE EXPENDITURES TARGETS TO PROMOTE PROGRAM EQUITY ACROSS STATES.—

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

"(B) ADJUSTMENT BASED ON LEVEL OF PER CAPITA SPENDING FOR 1903A ENROLLEE CATEGORIES.—Subject to subparagraph (C), with respect to a State, fiscal year, and 1903A enrollee category, if the State's per capita categorical medical assistance expenditures (as defined in subparagraph (D)) for the State and category in the preceding fiscal year—

"(i) exceed the mean per capita categorical medical assistance expenditures for the category for all States for such preceding year by not less than 25 percent, the State's target per capita medical assistance expenditures for such category for the fiscal year involved shall be reduced by

a percentage that shall be determined by the Secretary but which shall not be less than 0.5 percent or greater than 3 percent; or

''(ii) are less than the mean per capita categorical medical assistance expenditures for the category for all States for such preceding year by not less than 25 percent, the State's target per capita medical assistance expenditures for such category for the fiscal year involved shall be increased by a percentage that shall be determined by the Secretary but which shall not be less than 0.5 percent or greater than 3 percent.

''(C) RULES OF APPLICATION.—

''(i) BUDGET NEUTRALITY REQUIREMENT.—In determining the appropriate percentages by which to adjust States' target per capita medical assistance expenditures for a category and fiscal year under this paragraph, the Secretary shall make such adjustments in a manner that does not result in a net increase in Federal payments under this section for such fiscal

year, and if the Secretary cannot adjust such expenditures in such a manner there shall be no adjustment under this paragraph for such fiscal year.

"(ii) ASSUMPTION REGARDING STATE EXPENDITURES.—For purposes of clause (i), in the case of a State that has its target per capita medical assistance expenditures for a 1903A enrollee category and fiscal year increased under this paragraph, the Secretary shall assume that the categorical medical assistance expenditures (as defined in subparagraph (D)(ii)) for such State, category, and fiscal year will equal such increased target medical assistance expenditures.

"(iii) NONAPPLICATION TO LOW-DENSITY STATES.—This paragraph shall not apply to any State that has a population density of less than 15 individuals per square mile, based on the most recent data available from the Bureau of the Census.

"(iv) DISREGARD OF ADJUSTMENT.—Any adjustment under this paragraph to target medical assistance expenditures for

a State, 1903A enrollee category, and fiscal year shall be disregarded when determining the target medical assistance expenditures for such State and category for a succeeding year under paragraph (2).

''(v) APPLICATION FOR FISCAL YEARS 2020 AND 2021.—In fiscal years 2020 and 2021, the Secretary shall apply this paragraph by deeming all categories of 1903A enrollees to be a single category.

''(D) PER CAPITA CATEGORICAL MEDICAL ASSISTANCE EXPENDITURES.—

''(i) IN GENERAL.—In this paragraph, the term 'per capita categorical medical assistance expenditures' means, with respect to a State, 1903A enrollee category, and fiscal year, an amount equal to—

''(I) the categorical medical expenditures (as defined in clause (ii)) for the State, category, and year; divided by

''(II) the number of 1903A enrollees for the State, category, and year.

"(ii) CATEGORICAL MEDICAL ASSISTANCE EXPENDITURES.—The term 'categorical medical assistance expenditures' means, with respect to a State, 1903A enrollee category, and fiscal year, an amount equal to the total medical assistance expenditures (as defined in paragraph (2)) for the State and fiscal year that are attributable to 1903A enrollees in the category, excluding any excluded expenditures (as defined in paragraph (3)) for the State and fiscal year that are attributable to 1903A enrollees in the category.

"(d) CALCULATION OF FY19 PROVISIONAL TARGET AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—Subject to subsection (g), the following shall apply:

"(1) CALCULATION OF BASE AMOUNTS FOR PER CAPITA BASE PERIOD.—For each State the Secretary shall calculate (and provide notice to the State not later than April 1, 2018, of) the following:

"(A) The amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State for the State's per capita base period.

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

"(C) The average per capita medical assistance expenditures for the State for the State's per capita base period equal to—

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

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

"(2) FISCAL YEAR 2019 AVERAGE PER CAPITA AMOUNT BASED ON INFLATING THE PER CAPITA BASE PERIOD AMOUNT TO FISCAL YEAR 2019 BY CPI-MEDICAL.—The Secretary shall calculate a fiscal year 2019 average per capita amount for each State equal to—

"(A) the average per capita medical assistance expenditures for the State for the State's per capita base period (calculated under paragraph (1)(C)); increased by

"(B) the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from 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 subsection (b)(1)) for the State for fiscal year 2019.

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

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

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

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

"(I) is not made under section 1923;

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

"(III) is in addition to any payments made to the provider under the plan (or waiver) for any such item or service; and

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

"(iii) An expenditure described in this clause is an expenditure that meets the criteria specified in subclauses (I), (II), and (III) of clause (ii) and is authorized under section 1115 for the purposes of funding a delivery system reform pool, uncompensated care pool, a designated State health program, or any other

similar expenditure (as defined by the Secretary).

''(B) For each 1903A enrollee category, the number of 1903A enrollees for the State in fiscal year 2019 in the enrollee category (as determined under subsection (e)(4)).

''(C) For the State's per capita base period, the State's non-DSH supplemental and pool payment percentage is equal to the ratio (expressed as a percentage) of—

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

''(ii) the amount described in subsection (b)(1)(A) for the State for the State's per capita base period.

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

"(i) the amount calculated under subparagraph (A) for the State, increased by the non-DSH supplemental and pool payment percentage for the State (as calculated under subparagraph (C)); divided by

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

"(E) For purposes of subparagraph (C)(i), in calculating the total amount of non-DSH supplemental expenditures and payments described in subparagraph (A)(iii) for a State for the per capita base period, the total amount of such expenditures and the total amount of such payments for the State and base period shall each be divided by 2.

"(5) PROVISIONAL FY19 PER CAPITA TARGET AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—Subject to subsection (f)(2), the Secretary shall calculate for each State a provisional FY19 per capita target amount for each 1903A enrollee category equal to the average medical assistance expenditures per capita for the State for fiscal year 2019 (as cal-

culated under paragraph (4)(D)) for such enrollee category multiplied by the ratio of—

"(A) the product of—

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

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

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

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

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

"(A) CHIP.—An individual who is provided, under this title in the manner described

in section 2101(a)(2), child health assistance under title XXI.

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

''(C) BREAST AND CERVICAL CANCER SERVICES ELIGIBLE INDIVIDUAL.—An individual who is eligible for medical assistance under this title only on the basis of section 1902(a)(10)(A)(ii)(XVIII).

''(D) PARTIAL-BENEFIT ENROLLEES.—An individual who—

''(i) is an alien who is eligible for medical assistance under this title only on the basis of section 1903(v)(2);

''(ii) is eligible for medical assistance under this title only on the basis of subclause (XII) or (XXI) of section 1902(a)(10)(A)(ii) (or on the basis of a waiver that provides only comparable benefits);

''(iii) is a dual eligible individual (as defined in section 1915(h)(2)(B)) and is eligible for medical assistance under this

title (or under a waiver) only for some or all of medicare cost-sharing (as defined in section 1905(p)(3)); or

''(iv) is eligible for medical assistance under this title and for whom the State is providing a payment or subsidy to an employer for coverage of the individual under a group health plan pursuant to section 1906 or section 1906A (or pursuant to a waiver that provides only comparable benefits).

''(E) BLIND AND DISABLED CHILDREN.—An individual who—

''(i) is a child under 19 years of age; and

''(ii) is eligible for medical assistance under this title on the basis of being blind or disabled.

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

''(A) ELDERLY.—A category of 1903A enrollees who are 65 years of age or older.

"(B) BLIND AND DISABLED.—A category of 1903A enrollees (not described in the previous subparagraph) who—

"(i) are 19 years of age or older; and

"(ii) are eligible for medical assistance under this title on the basis of being blind or disabled.

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

"(D) EXPANSION ENROLLEES.—A category of 1903A enrollees (not described in a previous subparagraph) who are eligible for medical assistance under this title only on the basis of clause (i)(VIII), (ii)(XX), or (ii)(XXIII) of section 1902(a)(10)(A).

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

"(3) MEDICAID ENROLLEE.—The term 'Medicaid enrollee' means, with respect to a State for a month, an individual who is eligible for medical assistance for items or services under this title and en-

rolled under the State plan (or a waiver of such plan) under this title for the month.

''(4) DETERMINATION OF NUMBER OF 1903A ENROLLEES.—The number of 1903A enrollees for a State and fiscal year or the State's per capita base period, and, if applicable, for a 1903A enrollee category, is the average monthly number of Medicaid enrollees for such State and fiscal year or base period (and, if applicable, in such category) that are reported through the CMS–64 report under (and subject to audit under) subsection (h).

''(f) SPECIAL PAYMENT RULES.—

''(1) APPLICATION IN CASE OF RESEARCH AND DEMONSTRATION PROJECTS AND OTHER WAIVERS.—In the case of a State with a waiver of the State plan approved under section 1115, section 1915, or another provision of this title, this section shall apply to medical assistance expenditures and medical assistance payments under the waiver, in the same manner as if such expenditures and payments had been made under a State plan under this title and the limitations on expenditures under this section shall supersede any other payment limitations or provisions (including limitations based on a per cap-

ita limitation) otherwise applicable under such a waiver.

''(2) TREATMENT OF STATES EXPANDING COVERAGE AFTER JULY 1, 2016.—In the case of a State that did not provide for medical assistance for the 1903A enrollee category described in subsection (e)(2)(D) as of July 1, 2016, but which subsequently provides for such assistance for such category, the provisional FY19 per capita target amount for such enrollee category under subsection (d)(5) shall be equal to the provisional FY19 per capita target amount for the 1903A enrollee category described in subsection (e)(2)(E).

''(3) IN CASE OF STATE FAILURE TO REPORT NECESSARY DATA.—If a State for any quarter in a fiscal year (beginning with fiscal year 2019) fails to satisfactorily submit data on expenditures and enrollees in accordance with subsection (h)(1), for such fiscal year and any succeeding fiscal year for which such data are not satisfactorily submitted—

''(A) the Secretary shall calculate and apply subsections (a) through (e) with respect to the State as if all 1903A enrollee categories for which such expenditure and enrollee data

were not satisfactorily submitted were a single 1903A enrollee category; and

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

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

''(h) REQUIRED REPORTING AND AUDITING; TRANSITIONAL INCREASE IN FEDERAL MATCHING PERCENTAGE FOR CERTAIN ADMINISTRATIVE EXPENSES.—

"(1) REPORTING OF CMS–64 DATA.—

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

"(B) REPORTING ON QUALIFIED INPATIENT PSYCHIATRIC HOSPITAL SERVICES.—Not later than 60 days after the date of the enactment of this section, the Secretary shall modify the CMS–64 report form to require that States submit data with respect to medical assistance

expenditures for qualified inpatient psychiatric hospital services (as defined in section 1905(h)(3)).

''(C) REPORTING ON CHILDREN WITH COMPLEX MEDICAL CONDITIONS.—Not later than January 1, 2020, the Secretary shall modify the CMS–64 report form to require that States submit data with respect to individuals who—

''(i) are enrolled in a State plan under this title or title XXI or under a waiver of such plan;

''(ii) are under 21 years of age; and

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

''(I) affects two or more body systems;

''(II) affects cognitive or physical functioning (such as reducing the ability to perform the activities of daily living, including the ability to engage in movement or mobility, eat, drink, communicate, or breathe independently); and

''(III) either—

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

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

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

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

''(4) TEMPORARY INCREASE IN FEDERAL MATCHING PERCENTAGE TO SUPPORT IMPROVED DATA REPORTING SYSTEMS FOR FISCAL YEARS 2018 AND 2019.—In the case of any State that selects as its per capita base period the most recent 8 consecutive quarter period for which the data necessary to make the determinations required under this section is available, for amounts expended during calendar quarters beginning on or after October 1, 2017, and before October 1, 2019—

"(A) the Federal matching percentage applied under section 1903(a)(3)(A)(i) shall be increased by 10 percentage points to 100 percent;

"(B) the Federal matching percentage applied under section 1903(a)(3)(B) shall be increased by 25 percentage points to 100 percent; and

"(C) the Federal matching percentage applied under section 1903(a)(7) shall be increased by 10 percentage points to 60 percent but only with respect to amounts expended that are attributable to a State's additional administrative expenditures to implement the data requirements of paragraph (1).

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

(b) ENSURING ACCESS TO HOME AND COMMUNITY BASED SERVICES.—Section 1915 of the Social Security

Act (42 U.S.C. 1396n) is amended by adding at the end the following new subsection:

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

"(1) IN GENERAL.—The Secretary shall 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 continuing to provide and improving the quality of home and community-based services provided under a waiver under subsection (c) or (d) or a State plan amendment under subsection (i).

"(2) SELECTION OF ELIGIBLE STATES.—

"(A) APPLICATION.—A State seeking to participate in the demonstration project shall submit to the Secretary, at such time and in such manner as the Secretary shall require, an application that includes—

"(i) an assurance that any HCBS payment adjustment made by the State under this subsection will comply with the health and welfare and financial accountability safeguards taken by the State under subsection (c)(2)(A); and

"(ii) such other information and assurances as the Secretary shall require.

"(B) SELECTION.—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.

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

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

"(A) IN GENERAL.—

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

"(ii) LIMITATION ON FEDERAL SPENDING.—The aggregate amount that

may be allotted to eligible States under clause (i) for all years of the demonstration project shall not exceed $8,000,000,000, and in no case may the aggregate amount of payments made by the Secretary to eligible States for payment adjustments under this subsection exceed such amount.

''(B) PAYMENTS TO ELIGIBLE STATES AND LIMITATIONS ON PAYMENTS.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), for each year of the demonstration project, notwithstanding section 1905(b), the Federal medical assistance percentage applicable with respect to expenditures by an eligible State that are attributable to HCBS payment adjustments shall be equal to (and shall in no case exceed) 100 percent.

''(ii) LIMITATION ON HCBS PAYMENT ADJUSTMENTS FOR INDIVIDUAL PROVIDERS.—Payment under section 1903(a) shall not be made to an eligible State for expenditures for a year that are attributable to an HCBS payment adjustment

that is paid to a single provider and exceeds a percentage which shall be established by the Secretary of the payment otherwise made to the provider.

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

"(5) REPORTING AND EVALUATION.—

"(A) 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 and evaluating the State's compliance with the health and welfare and financial accountability safeguards taken by the State under subsection (c)(2)(A).

''(B) FORMS.—Expenditures by eligible States on HCBS payment adjustments shall be separately reported on the CMS-64 Form and in T-MSIS.

''(6) DEFINITIONS.—In this subsection:

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

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

''(ii) has in effect—

''(I) a waiver under subsection (c) or (d); or

''(II) a State plan amendment under subsection (i);

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

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

''(B) HCBS PAYMENT ADJUSTMENT.—The term 'HCBS payment adjustment' means a payment adjustment made by an eligible State to the amount of payment otherwise provided under a waiver under subsection (c) or (d) or a State plan amendment under subsection (i) for a home and community-based service which

is provided to a 1903A enrollee (as defined in section 1903A(e)(1)) who is in the enrollee category described in subparagraph (A) or (B) of section 1903A(e)(2).''.

SEC. 133. 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 2020, any State (as defined in subsection (e)) that has an application approved by the Secretary under subsection (b) may conduct a Medicaid Flexibility Program to provide targeted health assistance to program enrollees.

''(b) STATE APPLICATION.—

''(1) 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.

''(2) 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 under 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) report annually to the Secretary on adult health quality measures implemented under the program and information on the quality of health care furnished to program enrollees under the program as part of the annual report required under section 1139B(d)(1);

"(iv) submit 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—

"(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 labora-

tory 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 administration of the program and comply with reporting requirements under this section.

"(H) A statement of the goals of the proposed program, which shall include—

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

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

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

"(I) Such other information as the Secretary may require.

"(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 opportunities for a meaningful level of public input, which shall include public hearings on the proposed Medicaid Flexibility Program.

''(4) FEDERAL NOTICE AND COMMENT PERIOD.—The Secretary shall not approve of any application to conduct a Medicaid Flexibility Program without making such application publicly available for a 30 day notice and comment period.

''(5) TIMELINE FOR SUBMISSION.—

''(A) IN GENERAL.—A State may submit an application under this subsection to conduct a Medicaid Flexibility Program that would begin in the next fiscal year at any time, subject to subparagraph (B).

''(B) DEADLINES.—Each year beginning with 2019, the Secretary shall specify a deadline for submitting an application under this subsection to conduct a Medicaid Flexibility

Program that would begin in the next fiscal year, but such deadline shall not be earlier than 60 days after the date that the Secretary publishes the amounts of State block grants as required under subsection (c)(4).

''(c) FINANCING.—

''(1) IN GENERAL.—For each fiscal year during which a State is conducting a Medicaid Flexibility Program, the State shall receive, instead of amounts otherwise payable to the State under this title for medical assistance for program enrollees, the amount specified in paragraph (3)(A).

''(2) AMOUNT OF BLOCK GRANT FUNDS.—

''(A) IN GENERAL.—The block grant amount under this paragraph for a State and year shall be equal to the sum of the amounts 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 for the State, year, and category shall be equal to the Federal average medical assistance matching percentage (as defined in section 1903A(a)(4)) for the State and year multiplied by the product of—

"(I) the target per capita medical assistance expenditures (as defined in section 1903A(c)(2)) for the State, year, and category; and

"(II) the number of 1903A enrollees in such category for the State for the second fiscal year preceding such first fiscal year, increased by the percentage increase in State population from such second preceding fiscal year to such first fiscal year, based on the best available estimates of the Bureau of the Census.

"(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 paragraph for the State, year, and category shall be equal to the amount determined for the State and category for the most recent previous fiscal year in which the State conducted 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 preceding 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 number of 1903A enrollees in the enrollee category for the State for the State's per capita base period (as determined under section 1903A(e)(4)), increased by the percentage increase, if any, in the total State population from the last April in the State's per capita base period to April of the fiscal year preceding the fiscal year involved (determined using the best available data from the Bureau of the Census) plus 3 percentage points.

"(D) AVAILABILITY OF ROLLOVER FUNDS.—

"(i) IN GENERAL.—To the extent that the block grant amount available to a State for a fiscal year under this para-

graph exceeds the amount of Federal payments made to the State for such fiscal year under paragraph (3)(A), the Secretary shall make such funds available to the State for the succeeding fiscal year if the State—

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

"(II) is conducting a Medicaid Flexibility Program in such succeeding fiscal year.

"(ii) USE OF FUNDS.—Funds made available to a State under this subparagraph shall only be used for expenditures related to the State plan under this title or to the State Medicaid Flexibility Program.

"(3) FEDERAL PAYMENT AND STATE MAINTENANCE OF EFFORT.—

"(A) FEDERAL PAYMENT.—Subject to subparagraphs (D) and (E), the Secretary shall pay to each State conducting a Medicaid Flexibility Program under this section for a fiscal year, from its block grant amount under paragraph (2) for such year, an amount for each

quarter of such year equal to the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) of the total amount expended under the program during such quarter as targeted health assistance, and the State is responsible for the balance of the funds to carry out such program.

''(B) STATE MAINTENANCE OF EFFORT EXPENDITURES.—For each year during which a State is conducting a Medicaid Flexibility Program, the State shall make expenditures for targeted health assistance under the program in an amount equal to the product of—

''(i) the block grant amount determined for the State and year under paragraph (2); and

''(ii) the enhanced FMAP described in the first sentence of section 2105(b) for the State and year.

''(C) REDUCTION IN BLOCK GRANT AMOUNT FOR STATES FAILING TO MEET MOE REQUIREMENT.—

''(i) IN GENERAL.—In the case of a State conducting a Medicaid Flexibility Program that makes expenditures for tar-

geted health assistance under the program for a fiscal year in an amount that is less than the required amount for the fiscal year under subparagraph (B), the amount of the block grant determined for the State under paragraph (2) for the succeeding fiscal year shall be reduced by the amount by which such expenditures are less than such required amount.

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

''(iii) APPLICATION TO STATES THAT TERMINATE PROGRAM.—In the case of a State described in clause (i) that terminates the State Medicaid Flexibility Program under subsection (d)(2)(B) and such termination is effective with the end of the fiscal year in which the State fails to make the required amount of expenditures under subparagraph (B), the reduction amount determined for the State and succeeding

fiscal year under clause (i) shall be treated as an overpayment under this title.

''(D) REDUCTION FOR NONCOMPLIANCE.—If the Secretary determines that a State conducting a Medicaid Flexibility Program is not complying with the requirements of this section, the Secretary may withhold payments, reduce payments, or recover previous payments to the State under this section as the Secretary deems appropriate.

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

''(i) IN GENERAL.—In the case of a State and fiscal year or portion of a fiscal year for which the Secretary has excluded expenditures under section 1903A(b)(6), if the State has uncompensated targeted health assistance expenditures for the year or portion of a year, the Secretary may make an additional payment to such State equal to the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) for the year or portion of a year of the amount of such uncompensated targeted health assistance expenditures, ex-

cept that the amount of such payment shall not exceed the amount determined for the State and year or portion of a year under clause (ii).

''(ii) MAXIMUM AMOUNT OF ADDITIONAL PAYMENT.—The amount determined for a State and fiscal year or portion of a fiscal year under this subparagraph shall not exceed the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) for such year or portion of a year of the amount by which—

''(I) the amount of State expenditures for targeted health assistance for program enrollees in areas of the State which are subject to a declaration described in section 1903A(b)(6)(A)(i) for the year or portion of a year; exceeds

''(II) the amount of such expenditures for such enrollees in such areas during the most recent fiscal year involved (or portion of a fiscal year of equal length to the portion of a fiscal

year involved) during which no such declaration was in effect.

''(iii) UNCOMPENSATED TARGETED HEALTH ASSISTANCE.—In this subparagraph, the term 'uncompensated targeted health assistance expenditures' means, with respect to a State and fiscal year or portion of a fiscal year, an amount equal to the amount (if any) by which—

''(I) the total amount expended by the State under the program for targeted health assistance for the year or portion of a year; exceeds

''(II) the amount equal to the amount of the block grant (reduced, in the case of a portion of a year, to the same proportion of the full block grant amount that the portion of the year bears to the whole year) divided by the Federal average medical assistance percentage for the year or portion of a year.

''(iv) REVIEW.—If the Secretary makes a payment to a State for a fiscal year or portion of a fiscal year, the Sec-

retary shall, not later than 6 months after the declaration described in section 1903A(b)(6)(A)(i) ceases to be in effect, conduct an audit of the State's targeted health assistance expenditures for program enrollees during the year or portion of a year to ensure that all of the expenditures for which the additional payment was made were made for the purpose of ensuring that the health care needs of program enrollees in areas affected by a public health emergency are met.

''(4) DETERMINATION AND PUBLICATION OF BLOCK GRANT AMOUNT.—Beginning in 2019 and each year thereafter, the Secretary shall determine for each State, regardless of whether the State is conducting a Medicaid Flexibility Program or has submitted an application to conduct such a program, the amount of the block grant for the State under paragraph (2) which would apply for the upcoming fiscal year if the State were to conduct such a program in such fiscal year, 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 conducting a Medicaid Flexibility Program unless such program meets the requirements of this subsection.

"(2) TERM OF PROGRAM.—

"(A) IN GENERAL.—A State Medicaid Flexibility Program approved under subsection (b)—

"(i) shall be conducted for not less than 1 program period;

"(ii) at the option of the State, may be continued for succeeding program periods without resubmitting an application under subsection (b), provided that—

"(I) the State provides notice to the Secretary of its decision to continue the program; and

"(II) no significant changes are made to the program; and

"(iii) shall be subject to termination only by the State, which may terminate the program by making an election under subparagraph (B).

"(B) ELECTION TO TERMINATE PROGRAM.—

"(i) IN GENERAL.—Subject to clause (ii), a State conducting a Medicaid Flexibility Program may elect to terminate the program effective 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 approved by the Secretary.

"(iii) EFFECT OF TERMINATION.—If a State elects 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 ASSISTANCE.—

"(A) IN GENERAL.—A State Medicaid Flexibility Program shall provide targeted health assistance to program enrollees and such assistance shall be instead of medical assistance

which would otherwise be provided to the enrollees under this title.

"(B) CONDITIONS FOR ELIGIBILITY.—

"(i) IN GENERAL.—A State conducting a Medicaid Flexibility Program shall establish conditions for eligibility of program enrollees, which shall be instead of other conditions for eligibility under this title, except that the program must provide for eligibility for program enrollees to whom the State would otherwise be required to make medical assistance available under section 1902(a)(10)(A)(i).

"(ii) MAGI.—Any determination of income necessary to establish the eligibility of a program enrollee for purposes of a State Medicaid Flexibility Program shall be made using modified adjusted gross income in accordance with section 1902(e)(14).

"(4) BENEFITS AND SERVICES.—

"(A) REQUIRED SERVICES.—In the case of program enrollees to whom the State would otherwise be required to make medical assistance available under section 1902(a)(10)(A)(i), a

State conducting a Medicaid Flexibility Program shall provide as targeted health assistance the following types of services:

"(i) Inpatient and outpatient hospital services.

"(ii) Laboratory and X-ray services.

"(iii) Nursing facility services for individuals aged 21 and older.

"(iv) Physician services.

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

"(vi) Rural health clinic services (as defined in section 1905(l)(1)).

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

"(viii) Family planning services and supplies.

"(ix) Nurse midwife services.

"(x) Certified pediatric and family nurse practitioner services.

"(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, including postpartum services for the 12-week period beginning on the last day of a pregnancy.

"(B) OPTIONAL BENEFITS.—A State may, at its option, provide services in addition to the services described in subparagraph (A) as targeted health assistance under a Medicaid Flexibility Program.

"(C) BENEFIT PACKAGES.—

"(i) IN GENERAL.—The targeted health assistance provided by a State to any group of program enrollees under a Medicaid Flexibility Program shall have an aggregate actuarial value that is equal to at least 95 percent of the aggregate actuarial value of the benchmark coverage described in subsection (b)(1) of section 1937 or benchmark-equivalent coverage described in subsection (b)(2) of such section, as such subsections were in effect prior to the enactment of the Patient Protection and Affordable Care Act.

"(ii) AMOUNT, DURATION, AND SCOPE OF BENEFITS.—Subject to clause (i), the State shall determine the amount, duration, and scope with respect to services provided as targeted health assistance under a Medicaid Flexibility Program, including with respect to services that are required to be provided to certain program enrollees under subparagraph (A) except as otherwise provided under such subparagraph.

"(iii) MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE AND PARITY.—The targeted health assistance provided by a State to program enrollees under a Medicaid Flexibility Program shall include mental health services and substance use disorder services and the financial requirements and treatment limitations applicable to such services under the program shall comply with the requirements of section 2726 of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

"(iv) PRESCRIPTION DRUGS.—If the targeted health assistance provided by a State to program enrollees under a Medicaid Flexibility Program includes assistance for covered outpatient drugs, such drugs shall be subject to a rebate agreement that complies with the requirements of section 1927, and any requirements applicable to medical assistance for covered outpatient drugs under a State plan (including the requirement that the State provide information to a manufacturer) shall apply in the same manner to targeted health assistance for covered outpatient drugs under a Medicaid Flexibility Program.

"(D) COST SHARING.—A State conducting a Medicaid Flexibility Program may impose premiums, deductibles, cost-sharing, or other similar charges, except that the total annual aggregate amount of all such charges imposed with respect to all program enrollees in a family shall not exceed 5 percent of the family's income for the year involved.

''(5) ADMINISTRATION OF PROGRAM.—Each State conducting a Medicaid Flexibility Program shall do the following:

''(A) SINGLE AGENCY.—Designate a single State agency responsible for administering the program.

''(B) ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.—Provide for simplified enrollment processes (such as online enrollment and reenrollment and electronic verification) and coordination with State health insurance exchanges.

''(C) BENEFICIARY PROTECTIONS.—Establish a fair process (which the State shall describe in the application required under subsection (b)) for individuals to appeal adverse eligibility determinations with respect to the program.

''(6) APPLICATION OF REST OF TITLE XIX.—

''(A) IN GENERAL.—To the extent that a provision of this section is inconsistent with another provision of this title, the provision of this section shall apply.

"(B) APPLICATION OF SECTION 1903A.—With respect to a State that is conducting a Medicaid Flexibility Program, section 1903A shall be applied as if program enrollees were not 1903A enrollees for each program period during which the State conducts the program.

"(C) WAIVERS AND STATE PLAN AMENDMENTS.—

"(i) IN GENERAL.—In the case of a State conducting a Medicaid Flexibility Program that has in effect a waiver or State plan amendment, such waiver or amendment shall not apply with respect to the program, targeted health assistance provided under the program, or program enrollees.

"(ii) REPLICATION OF WAIVER OR AMENDMENT.—In designing a Medicaid Flexibility Program, a State may mirror provisions of a waiver or State plan amendment described in clause (i) in the program to the extent that such provisions are otherwise consistent with the requirements of this section.

"(iii) EFFECT OF TERMINATION.—In the case of a State described in clause (i) that terminates its program under subsection (d)(2)(B), any waiver or amendment which was limited pursuant to subparagraph (A) shall cease to be so limited effective with the effective date of such termination.

"(D) NONAPPLICATION OF PROVISIONS.—With respect to the design and implementation of Medicaid Flexibility Programs conducted under this section, paragraphs (1), (10)(B), (17), and (23) of section 1902(a), as well as any other provision of this title (except for this section and as otherwise provided by this section) that the Secretary deems appropriate, shall not apply.

"(e) DEFINITIONS.—For purposes of this section:

"(1) APPLICABLE PROGRAM ENROLLEE CATEGORY.—The term 'applicable program enrollee category' means, with respect to a State Medicaid Flexibility Program for a program period, any of the following as specified by the State for the period in its application under subsection (b):

''(A) 2 ENROLLEE CATEGORIES.—Both of the 1903A enrollee categories described in subparagraphs (D) and (E) of section 1903A(e)(2).

''(B) EXPANSION ENROLLEES.—The 1903A enrollee category described in subparagraph (D) of section 1903A(e)(2).

''(C) NONELDERLY, NONDISABLED, NONEXPANSION 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 State program for providing targeted health assistance to program enrollees funded by a block grant under this section.

''(3) PROGRAM ENROLLEE.—

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

''(B) RULE OF CONSTRUCTION.—For purposes of section 1903A(e)(3), eligibility and en-

rollment of an individual under a Medicaid Flexibility Program shall be deemed to be eligibility and enrollment 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) STATE.—The term 'State' means one of the 50 States or the District of Columbia.

''(6) TARGETED HEALTH ASSISTANCE.—The term 'targeted health assistance' means assistance for health-care-related items and 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:

''(bb) QUALITY PERFORMANCE BONUS PAYMENTS.—

''(1) INCREASED FEDERAL SHARE.—With respect to each of fiscal years 2023 through 2026, in the case of one of the 50 States or the District of Columbia (each referred to in this subsection as a 'State') that—

''(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) submits to 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—

''(i) information on the applicable quality measures identified under paragraph (3) with respect to each category of Medicaid eligible individuals under 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 applied under subsection (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) ALLOTMENT DETERMINATION.—The Secretary shall establish a formula for computing State allotments under this paragraph for each fiscal year described in paragraph (1) such that—

''(A) such an allotment to a State is determined based on the performance, including improvement, of such State under this title and title XXI with respect to the 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 the quality measures that are overseen or developed by the National Committee for Quality Assurance or the Agency for Healthcare Research and Quality or that are identified under section 1139A or 1139B) that are quantifiable, objective measures that take into account the clinically appropriate measures of quality for different types of patient populations receiving benefits or services under this title or title XXI.

''(4) LOWER THAN EXPECTED AGGREGATE MEDICAL ASSISTANCE EXPENDITURES.—In this subsection, the term 'lower than expected aggregate medical assistance expenditures' means, with respect to a State the amount (if any) by which—

''(A) the amount of the adjusted total medical assistance expenditures for the State and fiscal year determined in section 1903A(b)(1)

without regard to the 1903A enrollee category described in section 1903A(e)(2)(E); is less than

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

SEC. 135. GRANDFATHERING CERTAIN MEDICAID WAIVERS; PRIORITIZATION OF HCBS WAIVERS.

(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 State plan under 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, so long as the terms and conditions of the waiver involved (other than such terms and conditions that relate to budget neutrality as modified pursuant to section 1903A(f)(1) of the Social Security Act) are not modified.

(2) MODIFICATIONS.—

(A) IN GENERAL.—If a State with a grandfathered managed care waiver seeks to 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—

(I) a denial; or

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

(ii) ADDITIONAL INFORMATION.—If the Secretary requests additional information, the Secretary has 30 days after a State submission in response to the Secretary's request to deny the application or request more information.

(3) 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 such Act (or under a waiver of such plan under section 1115 of such Act) that—

(A) is approved by the Secretary of Health and Human Services under section 1915(b), 1932, or 1115(a)(1) of the Social Security Act (42 U.S.C. 1396n(b), 1396u–2, 1315(a)(1)) as of January 1, 2017; and

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

(b) HCBS WAIVERS.—The Secretary of Health and Human Services shall implement procedures encouraging States to adopt or extend waivers related to the authority of a State to make medical assistance available for home and community-based services under the State plan under title XIX of the Social Security Act if the State determines that such waivers would improve patient access to services.

SEC. 136. COORDINATION WITH STATES.

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

''COORDINATION WITH STATES

''SEC. 1904A. No proposed rule (as defined in section 551(4) of title 5, United States Code) implementing or interpreting any provision of this title shall be finalized on or after January 1, 2018, unless the Secretary—

''(1) provides for a process under which the Secretary or the Secretary's designee solicits advice from each State's State agency responsible for administering the State plan under this title (or a waiver of such plan) and State Medicaid Director—

''(A) on a regular, ongoing basis on matters relating to the application of this title that are likely to have a direct effect on the operation or financing of State plans under this title (or waivers of such plans); and

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

''(2) accepts and considers written and oral comments from a bipartisan, nonprofit, professional organization that represents State Medicaid Directors, and from any State agency administering the

plan under this title, regarding such proposed rule; and

''(3) incorporates in the preamble to the proposed rule a summary of comments referred to in paragraph (2) and the Secretary's response to such comments.''.

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

(a) STATE OPTION.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)—

(A) in paragraph (16)—

(i) by striking ''and, (B)'' and inserting ''(B)''; and

(ii) by inserting before the semicolon at the end the following: '', and (C) subject to subsection (h)(4), qualified inpatient psychiatric hospital services (as defined in subsection (h)(3)) for individuals who are over 21 years of age and under 65 years of age''; and

(B) in the subdivision (B) that follows paragraph (29), by inserting ''(other than services described in subparagraph (C) of paragraph (16) for individuals described in such

subparagraph)'' after ''patient in an institution for mental diseases''; and

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

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

''(A) in an institution (or distinct part thereof) which is a psychiatric hospital (as defined in section 1861(f)); and

''(B) with respect to such an individual, for a period not to exceed 30 consecutive days in any month and not to exceed 90 days in any calendar year.

''(4) As a condition for a State including qualified inpatient psychiatric hospital services as medical assistance under subsection (a)(16)(C), the State must (during the period in which it furnishes medical assistance under this title for services and individuals described in such subsection)—

''(A) maintain at least the number of licensed beds at psychiatric hospitals owned, operated, or

contracted for by the State that were being maintained as of the date of the enactment of this paragraph or, if higher, as of the date the State applies to the Secretary to include medical assistance under such subsection; and

''(B) maintain on an annual basis a level of funding expended by the State (and political subdivisions thereof) other than under this title from non-Federal funds for inpatient 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. 1395d(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)(16)(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. ENHANCED FMAP FOR MEDICAL ASSISTANCE TO ELIGIBLE INDIANS.

Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting ''and with respect to amounts expended by a State as medical assistance for services provided by any other provider under the State plan to an individual who is a member of an Indian tribe who is eligible for assistance under the State plan'' before the period.

SEC. 139. MEDICAID 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:

''CONSUMER-FOCUSED COST-SHARING ASSISTANCE FOR LOW-INCOME INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS

''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)) who is enrolled in a qualified

health plan offered on an Exchange if the State meets the requirements of this section and the offering of such assistance is cost-effective (as defined in subsection (d)).

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

''(1) whose income (as determined under section 1902(e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved;

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

''(3) who would be described in subparagraph (D) or (E) of section 1903A(e)(2) if the individual were eligible for medical assistance under the State plan; and

''(4) who satisfies such additional criteria for the provision of cost-sharing assistance under this section as the State may establish.

''(c) COST-SHARING ASSISTANCE DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'cost-sharing assistance' includes amounts expended for all or part of the costs of pre-

miums, deductibles, coinsurance, copayments, or similar charges, and all or part of any amounts paid for medical care (within the meaning of section 213(d) of the Internal Revenue Code of 1986).

''(2) OPTION OF ADDITIONAL BENEFITS.—Such term may include, at the option of a State, such additional benefits as the State may specify.

''(d) COST-EFFECTIVE DEFINED.—

''(1) IN GENERAL.—For purposes of this section, with respect to a 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 do not exceed the Federal cost-sharing assistance limit (as defined in paragraph (3)) for the State and year.

''(2) AGGREGATE AMOUNT OF FEDERAL COST-SHARING AND PREMIUM ASSISTANCE.—The term 'aggregate amount of Federal cost-sharing and premium assistance' means, for a State and year, the sum of—

''(A) the product of—

''(i) the Federal average medical assistance matching percentage (as defined

in section 1903A(a)(4)) for the State and year; and

"(ii) the amount of cost-sharing assistance provided to eligible low-income individuals by the State for the year; and

"(B) the amount of Federal expenditures attributable to advance payments for premium tax credits under section 1412(c)(2) of the Patient Protection and Affordable Care Act made on behalf of eligible low-income individuals in the State for the year.

"(3) FEDERAL COST-SHARING ASSISTANCE LIMIT.—The term 'Federal cost-sharing assistance limit' means, for a State and year, the product of—

"(A) the Federal average medical assistance matching percentage (as defined in section 1903A(a)(4)) for the State and year; and

"(B) the sum of the products, for each of the 1903A enrollee categories described in subparagraph (D) and (E) of section 1903A(e)(2), of—

"(i) the target per capita medical assistance expenditures for the State, year, and category; and

"(ii) the number of eligible low-income individuals in the State for the year who, if they were eligible for medical assistance, would be described in the category.

"(e) OTHER PROVISIONS.—

"(1) TREATMENT AS MEDICAL ASSISTANCE.—Expenditures for cost-sharing assistance provided by a State for a year in accordance with this section shall be considered, for purposes of section 1903, to be expenditures for medical assistance, except that—

"(A) notwithstanding section 1905(b), the Federal medical assistance percentage applicable to the total amount expended for such 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 the Federal 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) NOT CONSIDERED MINIMUM ESSENTIAL COVERAGE.—Cost-sharing assistance provided under this section shall not be considered to be minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

''(4) NONAPPLICATION OF OTHER REQUIREMENTS.—Sections 1902(a)(1) (relating to statewideness), 1902(a)(10)(B) (relating to comparability), 1916, and 1916A (relating to cost-sharing for medical assistance), and any other provision of this title which would be directly contrary to the authority under this section shall not apply to the provision of cost-sharing assistance under this section.''.

SEC. 140. SMALL BUSINESS HEALTH PLANS.

(a) TAX TREATMENT OF SMALL BUSINESS HEALTH PLANS.—A small business health plan (as defined in section 801(a) of the Employee Retirement Income Security Act of 1974) shall be treated—

(1) as a group health plan (as defined in section 2791 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);

(2) as a group health plan (as defined in section 5000(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

(3) as a group health plan (as defined in section 733(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)(1))) for purposes of applying parts 6 and 7 of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.).

(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).

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

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

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

''(3) is established as a permanent entity;

''(4) is established for a purpose other than providing health benefits to its members, such as an organization established as a bona fide trade association, franchise, or section 7705 organization; and

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

''SEC. 802. FILING FEE AND CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.

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

''(b) CERTIFICATION.—

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

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

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

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

''(D) shall conduct oversight of certified plan sponsors, including periodic review, and consistent with section 504, applying the requirements of sections 518, 519, and 520; and

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

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

"(A) Identifying information.

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

"(C) Bonding requirements.

"(D) Plan documents.

"(E) Agreements with service providers.

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

"(A) structure and requirements for boards of trustees or plan administrators;

"(B) notification of material changes; and

"(C) notification for voluntary termination.

"(c) 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.

''(d) 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 against the board of trustees, plan administrator, and plan sponsor (jointly and severally) of a small business health plan sponsor that is deemed certified under paragraph (1) of up to $500,000 in the event the Secretary determines that the application for certification of such small business health plan sponsor was willfully or with gross negligence incomplete or inaccurate.

''SEC. 803. PARTICIPATION AND COVERAGE REQUIREMENTS.

''(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to

a small business health plan if, under the terms of the plan—

"(1) each participating employer must be—

"(A) a member of the sponsor;

"(B) the sponsor; or

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

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

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

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

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

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

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

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

''SEC. 804. DEFINITIONS; RENEWAL.

''For purposes of this part:

''(1) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

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

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

"(2) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

"(3) FRANCHISOR; FRANCHISEE.—The terms 'franchisor' and 'franchisee' have the meanings given such terms for purposes of sections 436.2(a) through 436.2(c) of title 16, Code of Federal Regulations (including any such amendments to such regulation after the date of enactment of this part) and, for purposes of this part, franchisor or franchisee employers participating in such a group health plan shall not be treated as the employer, co-employer, or joint employer of the employees of another partici-

pating franchisor or franchisee employer for any purpose.

''(4) HEALTH PLAN TERMS.—The terms 'group health plan', 'health insurance coverage', and 'health insurance issuer' have the meanings given such terms in section 733.

''(5) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the

same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

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

''(7) SECTION 7705 ORGANIZATION.—The term 'section 7705 organization' means an organization providing services for a customer pursuant to a contract meeting the conditions of subparagraphs (A), (B), (C), (D), and (E) (but not (F)) of section 7705(e)(2) of the Internal Revenue Code of 1986, including an entity that is part of a section 7705 organization control group . For purposes of this part, any reference to 'member' shall include a customer of a section 7705 organization except with respect to

references to a 'member' or 'members' in paragraph (1).''.

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

''(f) The provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude a health insurance issuer from offering health insurance coverage in connection with a small business health plan which is certified under part 8.''.

(d) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes a person serving as the sponsor of a small business health plan under part 8.''.

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

(f) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this section within 6 months after the date of the enactment of this Act.

TITLE II

SEC. 201. THE PREVENTION AND PUBLIC HEALTH FUND.

Subsection (b) of section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 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).

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

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

(1) $4,972,000,000 for each of fiscal years 2018 through 2026, to provide grants to States to support substance use disorder treatment and recovery support services for individuals who have or may have mental or substance use disorders, including counseling, medication assisted treatment, and other substance abuse treatment and recovery services as such Secretary determines appropriate; and

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

Funds appropriated under this section shall remain available until expended.

SEC. 203. COMMUNITY HEALTH CENTER PROGRAM.

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

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

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

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

Section 2718(b) of the Public Health Service Act (42 U.S.C. 300gg–18(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 after such

date any reference in law 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) ENROLLMENT WAITING PERIODS.—Section 2702(b)(1) of the Public Health Services Act (42 U.S.C. 300gg–1(b)(1)) is amended by inserting '', and as described in paragraph (3)'' before the period.

(b) CREDITABLE COVERAGE REQUIREMENT.—Section 2702(b)(2) of the Public Health Services 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 Services 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.—With respect to health insurance coverage that is effective on or after January 1, 2019, a health insurance issuer described in subsection (a) that offers such coverage in the individual market shall impose a 6 month waiting period (as defined in the same manner as such term is defined in section 2704(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 without experiencing a significant break in such coverage as described in subparagraphs (A) and (B) of section 2704(c)(2); 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 day before the effective date of the coverage in which the individual is newly enrolling.

"(C) WAITING PERIOD DESCRIBED.—For purposes of subparagraph (A)—

"(i) in the case of an individual that submits an application during an open enrollment period or under a special enrollment period for which the individual qualifies, coverage under the plan begins on the first day of the first month that begins 6 months after the date on which the individual submits an application for health insurance coverage; 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 submits an application for health insurance coverage; or

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

"(D) CERTIFICATES OF CREDITABLE COVERAGE.—The Secretary shall require health insurance issuers and health care sharing min-

istries (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'—

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

''(ii) includes membership in a health care sharing ministry (as defined in section 5000A(d)(2)(B) of the Internal Revenue Code of 1986).

''(F) EXCEPTIONS.—Notwithstanding subparagraph (A), a health insurance issuer may not impose a waiting period with respect to the following individuals:

''(i) A newborn who is enrolled in such coverage within 30 days of the date of birth.

''(ii) A child who is adopted or placed for adoption before attaining 18 years of

age and who is enrolled in such coverage within 30 days of the date of the 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. 18052) is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) in subparagraph (B)—

(I) by amending clause (i) to read as follows:

''(i) a description of how the State plan meeting the requirements of a waiver under this section would, with respect to health insurance coverage within the State—

''(I) take the place of the requirements described in paragraph (2) that are waived; and

''(II) provide for alternative means of, and requirements for, increasing access to comprehensive coverage, reducing average premiums,

providing consumers the freedom to purchase the health insurance of their choice, and increasing enrollment in private health insurance; and''; and

(II) in clause (ii), by striking ''that is budget neutral for the Federal Government'' and inserting '', demonstrating that the State plan does not increase the Federal deficit''; and

(ii) in subparagraph (C), by striking ''the law'' and inserting ''a law or has in effect a certification'';

(B) in paragraph (3)—

(i) in the first sentence, by inserting ''or would qualify for a reduction in'' after ''would not qualify for'';

(ii) by adding after the second sentence the following: ''A State may request that all of, or any portion of, such aggregate amount of such credits or reductions be paid to the State as described in the first sentence.'';

(iii) in the paragraph heading, by striking ''PASS THROUGH OF FUNDING'' and inserting ''FUNDING'';

(iv) by striking ''With respect'' and inserting the following:

''(A) PASS THROUGH OF FUNDING.—With respect''; and

(v) 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(i) of the Social Security Act for the plan year, the State may use the funds available under the State's allotment for the plan year to carry out the State

plan under this section, so long as such use is consistent with the requirements of paragraphs (1) and (7) of section 2105(i) of such Act (other than paragraph (1)(B) 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 necessary to respond to an urgent or emergency situation with respect to health insurance coverage within a State.'';

(2) in subsection (b)—

(A) in paragraph (1)—

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

(I) by striking ''may'' and inserting ''shall''; and

(II) by striking ''only if'' and inserting ''unless''; and

(ii) by striking ''plan—'' and all that follows through the period at the end of subparagraph (D) and inserting ''application is missing a required element under subsection (a)(1) or that the State plan will increase the Federal deficit, not taking into account any amounts received through a grant under subsection (a)(3)(B).'';

(B) in paragraph (2)—

(i) in the paragraph heading, by inserting ''OR CERTIFY'' after ''LAW'';

(ii) in subparagraph (A), by inserting before the period '', and a certification described in this paragraph is a document, signed by the Governor, and the State insurance commissioner, of the State, that provides authority for State actions under a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B)''; and

(iii) in subparagraph (B)—

(I) in the subparagraph heading, by striking ''OF OPT OUT''; and

(II) by striking '' may repeal a law'' and all that follows through the

period at the end and inserting the following: ''may terminate the authority provided under the waiver with respect to the State by—

''(i) repealing a law described in subparagraph (A); or

''(ii) terminating a certification described in subparagraph (A), through a certification for such termination signed by the Governor, and the State insurance commissioner, of the State.'';

(3) in subsection (d)(2)(B), by striking ''and the reasons therefore'' and inserting ''and the reasons therefore, and provide the data on which such determination was made''; and

(4) in subsection (e), by striking ''No waiver'' and all that follows through the period at the end and inserting the following: ''A waiver under this section—

''(1) shall be in effect for a period of 8 years unless the State requests a shorter duration;

''(2) may be renewed for unlimited additional 8-year periods upon application by the State; and

"(3) may not be cancelled by the Secretary before the expiration of the 8-year period (including any renewal period under paragraph (2))."

(b) APPLICABILITY.—Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) shall apply as follows:

(1) In the case of a State for which a waiver under such section was granted prior to the date of enactment of this Act, such section 1332, as in effect on the day before the date of enactment of this Act shall apply to the waiver and State plan.

(2) In the case of a State that submitted an application for a waiver under such section prior to the date of enactment of this Act, and which application the Secretary of Health and Human Services has not approved prior to such date, the State may elect to have such section 1332, as in effect on the day before the date of enactment of this Act, or such section 1332, as amended by subsection (a), apply to such application and State plan.

(3) In the case of a State that submits an application for a waiver under such section on or after the date of enactment of this Act, such section 1332, as amended by subsection (a), shall apply to such application and State plan.

SEC. 208. ALLOWING ALL INDIVIDUALS PURCHASING HEALTH INSURANCE IN THE INDIVIDUAL MARKET THE OPTION TO PURCHASE A LOWER PREMIUM CATASTROPHIC PLAN.

(a) IN GENERAL.—Section 1302(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(e)) is amended by adding at the end the following:

''(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 1312(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(c)) is amended—

(1) in paragraph (1), by inserting ''and including, with respect to plan years beginning on or after January 1, 2019, enrollees in catastrophic plans described in section 1302(e)'' after ''Exchange''; 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 1302(e)'' after ''Exchange''.

SEC. 209. APPLICATION OF ENFORCEMENT PENALTIES.

(a) IN GENERAL.—Section 2723 of the Public Health Service Act (42 U.S.C. 300gg–22) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by inserting ''and of section 1303 of the Patient Protection and Affordable Care Act'' after ''this part''; and

(B) in paragraph (2), by inserting ''or in such section 1303'' after ''this part''; and

(2) in subsection (b)—

(A) in paragraphs (1) and (2)(A), by inserting ''or section 1303 of the Patient Protection and Affordable Care Act'' after ''this part'' each place such term appears;

(B) in paragraph (2)(C)(ii), by inserting ''and section 1303 of the Patient Protection and Affordable Care Act'' after ''this part''.

(b) EFFECT OF WAIVER.—A State waiver pursuant to section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) shall not affect the authority of the Secretary to impose penalties under section 2723 of the Public Health Service Act (42 U.S.C. 300gg–22).

SEC. 210. FUNDING FOR COST-SHARING PAYMENTS.

There is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary for payments for cost-sharing reductions authorized by the Patient Protection and Affordable Care Act (including adjustments to any prior obligations for such payments) for

the period beginning on the date of enactment of this Act and ending on December 31, 2019. Notwithstanding any other provision of this Act, payments and other actions for adjustments to any obligations incurred for plan years 2018 and 2019 may be made through December 31, 2020.

SEC. 211. REPEAL OF COST-SHARING SUBSIDY PROGRAM.

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

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

SEC. 212. CONDITIONS FOR RECEIVING ADDITIONAL SUPPORT FOR STABILIZING PREMIUMS AND PROMOTING CHOICE IN PLANS OFFERED IN THE INDIVIDUAL MARKET.

(a) FEDERAL FUNDING FOR PLANS.—If, for any of plan years 2020 through 2026 for which funds are available under subsection (h)(6) of section 2105 of the Social Security Act (42 U.S.C. 1397ee), a health insurance issuer (as defined in section 2791(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(2)) meets the conditions of subsection (b) with respect to an entire rating area within a State (as defined in section 2701(a)(2) of the Public Health Service Act (42 U.S.C. §

300gg(a)(2)), the provisions described in subsection (c) shall be treated as not applying (directly or through reference) for those plan years to health insurance coverage offered off the Exchange by such issuer in the individual market in the rating area in the State for such plan year (other than with respect to health insurance coverage certified under subsection (b)(2)), provided that such coverage offered off the Exchange complies with the applicable State health insurance requirements.

(b) CONDITIONS FOR FEDERAL FUNDING FOR PLANS.—The conditions of this subsection for a health insurance issuer for a plan year are that the health insurance issuer, on or before May 3 of the calendar year preceding the plan year involved—

(1) certifies to the Secretary and the applicable State insurance commissioner that such issuer will apply subsection (a) with respect to health insurance coverage in a rating area within a State for such plan year; and

(2) certifies to the Secretary that such issuer will make available through the Exchange in the rating area in the State in such plan year at least one gold level and one silver level qualified health plan (as described in section 1302(d)(1) of the Patient Protection and Affordable Care Act, 42 U.S.C.

18022(d)(1)) and one health plan that provides the level of coverage described in section 36B(b)(3)(B)(i) of the Internal Revenue Code of 1986.

(c) NON-APPLICABLE PROVISIONS DESCRIBED.—The provisions described in this subsection are the following:

(1) Subsections (b), (c)(1)(B), and (d) of section 1302 of the Patient Protection and Affordable Care Act (42 U.S.C. 18022).

(2) Section 2701(a)(1) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)).

(3) Subsections (a) and (b)(2) of section 2702 of the Public Health Service Act (42 U.S.C. §§ 300gg–1).

(4) Section 2704 of the Public Health Service Act (42 U.S.C. §§ 300gg–3).

(5) Subsections (a) through (j) of section 2705 of the Public Health Service Act (42 U.S.C. §§ 300gg–4).

(6) Section 2707 of the Public Health Service Act (42 U.S.C. 300gg–6).

(7) Section 2708 of the Public Health Service Act (42 U.S.C. 300gg–7).

(8) Section 2713(a) of the Public Health Service Act (42 U.S.C. 300gg–13(a)).

(9) Section 2718(b)(1) of the Public Health Service Act (42 U.S.C. §§ 300gg–18(b)(1)).

(d) CONTINUOUS COVERAGE.—For purposes of section 2702(b) of the Public Health Service Act (42 U.S.C. 300gg–1), health insurance coverage offered off the Exchange in accordance with subsection (a) shall not be deemed creditable coverage, as defined in section 2704(c) of the Public Health Service Act (42 U.S.C. 300gg–3(c)).

(e) NONAPPLICATION OF RISK ADJUSTMENT PROGRAM.—Section 1343 of the Patient Protection and Affordable Care Act (42 U.S.C. 18063) shall not apply to health insurance coverage offered off the Exchange in accordance with subsection (a) or to the issuer of such coverage with respect to that coverage.

(f) EFFECT OF WAIVER.—A State that receives a waiver under section 1332 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)(C) 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 for any health insurance 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. Funds appropriated under this paragraph shall remain available 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) TAX CREDIT NOT 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.