

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:

1 Strike all after the enacting clause and insert the following:
2

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Better Care Reconciliation Act of 2017”.
5

6 **TITLE I**

7 **SEC. 101. ELIMINATION OF LIMITATION ON RECAPTURE OF**

8 **EXCESS ADVANCE PAYMENTS OF PREMIUM**

9 **TAX CREDITS.**

10 Subparagraph (B) of section 36B(f)(2) of the Internal Revenue Code of 1986 is amended by adding at the
11 end the following new clause:
12

1 “(iii) NONAPPLICABILITY OF LIMITA-
2 TION.—This subparagraph shall not apply
3 to taxable years ending after December 31,
4 2017.”.

5 **SEC. 102. RESTRICTIONS FOR THE PREMIUM TAX CREDIT.**

6 (a) ELIGIBILITY FOR CREDIT.—

7 (1) IN GENERAL.—Section 36B(c)(1) of the In-
8 ternal Revenue Code of 1986 is amended—

9 (A) by striking “equals or exceeds 100 per-
10 cent but does not exceed 400 percent” in sub-
11 paragraph (A) and inserting “does not exceed
12 350 percent”, and

13 (B) by striking subparagraph (B) and re-
14 designating subparagraphs (C) and (D) as sub-
15 paragraphs (B) and (C), respectively.

16 (2) TREATMENT OF CERTAIN ALIENS.—

17 (A) IN GENERAL.—Paragraph (2) of sec-
18 tion 36B(e) of the Internal Revenue Code of
19 1986 is amended by striking “an alien lawfully
20 present in the United States” and inserting “a
21 qualified alien (within the meaning of section
22 431 of the Personal Responsibility and Work
23 Opportunity Reconciliation Act of 1996)”.

24 (B) AMENDMENTS TO PATIENT PROTEC-
25 TION AND AFFORDABLE CARE ACT.—

1 (i) Section 1411(a)(1) of the Patient
2 Protection and Affordable Care Act is
3 amended by striking “or an alien lawfully
4 present in the United States” and insert-
5 ing “or a qualified alien (within the mean-
6 ing of section 431 of the Personal Respon-
7 sibility and Work Opportunity Reconcili-
8 ation Act of 1996)”.

9 (ii) Section 1411(c)(2)(B) of such Act
10 is amended by striking “an alien lawfully
11 present in the United States” each place it
12 appears in clauses (i)(I) and (ii)(II) and
13 inserting “a qualified alien (within the
14 meaning of section 431 of the Personal Re-
15 sponsibility and Work Opportunity Rec-
16 onciliation Act of 1996)”.

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

19 (I) by striking “not lawfully
20 present in the United States” and in-
21 sserting “not citizens or nationals of
22 the United States or qualified aliens
23 (within the meaning of section 431 of
24 the Personal Responsibility and Work

1 Opportunity Reconciliation Act of
2 1996”, and

3 (II) by striking “INDIVIDUALS
4 NOT LAWFULLY PRESENT” in the
5 heading and inserting “CERTAIN
6 ALIENS”.

7 (b) MODIFICATION OF LIMITATION ON PREMIUM AS-
8 SISTANCE AMOUNT.—

9 (1) USE OF BENCHMARK PLAN.—

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

12 (i) by striking “applicable second low-
13 est cost silver plan” each place it appears
14 in paragraph (2)(B)(i) and (3)(C) and in-
15 serting “applicable median cost benchmark
16 plan”,

17 (ii) by striking “such silver plan” in
18 paragraph (3)(C) and inserting “such
19 benchmark plan”, and

20 (iii) in paragraph (3)(B)—

21 (I) by redesignating clauses (i)
22 and (ii) as clauses (iii) and (iv), re-
23 spectively, and by striking all that
24 precedes clause (iii) (as so redesign-
25 ated) and inserting the following:

1 “(B) APPLICABLE MEDIAN COST BENCH-
2 MARK PLAN.—The applicable median cost
3 benchmark plan with respect to any applicable
4 taxpayer is the qualified health plan offered in
5 the individual market in the rating area in
6 which the taxpayer resides which—

7 “(i) provides a level of coverage that
8 is designed to provide benefits that are ac-
9 tuarily equivalent to 58 percent of the
10 full actuarial value of the benefits (as de-
11 termined under rules similar to the rules of
12 paragraphs (2) and (3) of section 1302(d)
13 of the Patient Protection and Affordable
14 Care Act) provided under the plan,

15 “(ii) has a premium which is the me-
16 dian premium of all qualified health plans
17 described in clause (i) which are offered in
18 the individual market in such rating area
19 (or, in any case in which no such plan has
20 such median premium, has a premium
21 nearest (but not in excess of) such median
22 premium),” and

23 (II) by striking “clause (ii)(I)” in
24 the flush text at the end and inserting
25 “clause (iv)(I)”.

1 (B) WAIVER OF ACTUARIAL VALUE STAND-
2 ARD FOR BENCHMARK PLANS.—Section
3 36B(b)(3)(B) of the Internal Revenue Code of
4 1986, as amended by subparagraph (A), is
5 amended by adding at the end the following
6 new sentence: “If, for any plan year before
7 2027, the Secretary of the Treasury, in con-
8 sultation with the Secretary of Health and
9 Human Services, determines that there will be
10 no plan offered in a rating area in the indi-
11 vidual market that meets the level of coverage
12 described in clause (i), the Secretary of the
13 Treasury may increase the 58 percent amount
14 in such clause.”.

15 (2) MODIFICATION OF APPLICABLE PERCENT-
16 AGE.—Section 36B(b)(3)(A) of the Internal Revenue
17 Code of 1986 is amended—

18 (A) in clause (i), by striking “from the ini-
19 tial premium percentage” and all that follows
20 and inserting “from the initial percentage to
21 the final percentage specified in such table for
22 such income tier with respect to a taxpayer of
23 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”

1 (B) by striking “0.504” in clause (ii)(III)

2 and inserting “0.4”, and

3 (C) by adding at the end the following new

4 clause:

5 “(iii) AGE DETERMINATIONS.—For

6 purposes of clause (i), the age of the tax-

7 payer taken into account under clause (i)

8 with respect to any taxable year is the age

9 attained before the close of the taxable

10 year by the oldest individual taken into ac-

11 count on such taxpayer’s return who is

12 covered by a qualified health plan taken

13 into account under paragraph (2)(A).”.

14 (c) ELIMINATION OF ELIGIBILITY EXCEPTIONS FOR

15 EMPLOYER-SPONSORED COVERAGE.—

16 (1) IN GENERAL.—Section 36B(c)(2) of the In-

17 ternal Revenue Code of 1986 is amended by striking

18 subparagraph (C).

19 (2) AMENDMENTS RELATED TO QUALIFIED

20 SMALL EMPLOYER HEALTH REIMBURSEMENT AR-

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

3 (A) by striking “which constitutes afford-
4 able coverage” in subparagraph (A), and

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

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

10 (1) IN GENERAL.—Section 36B(c)(3)(A) of the
11 Internal Revenue Code of 1986 is amended by in-
12 serting at the end the following new sentence: “Such
13 term shall not include a plan that includes coverage
14 for abortions (other than any abortion necessary to
15 save the life of the mother or any abortion with re-
16 spect to a pregnancy that is the result of an act of
17 rape or incest).”.

18 (2) EFFECTIVE DATE.—The amendment made
19 by this subsection shall apply to taxable years begin-
20 ning after December 31, 2017.

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

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

3 (f) INCREASED PENALTY ON ERRONEOUS CLAIMS OF
4 CREDIT.—Section 6676(a) of the Internal Revenue Code
5 of 1986 is amended by inserting “(25 percent in the case
6 of a claim for refund or credit relating to the health insur-
7 ance coverage credit under section 36B)” after “20 per-
8 cent”.

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

12 **SEC. 103. MODIFICATIONS TO SMALL BUSINESS TAX CRED-**

13 **IT.**

14 (a) SUNSET.—

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

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

21 (2) EFFECTIVE DATE.—The amendment made
22 by this subsection shall apply to taxable years begin-
23 ning after December 31, 2019.

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

4 (1) IN GENERAL.—Subsection (h) of section
5 45R of the Internal Revenue Code of 1986 is
6 amended—

7 (A) by striking “Any term” and inserting
8 the following:

9 “(1) IN GENERAL.—Any term”, and

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

12 “(2) EXCLUSION OF CERTAIN HEALTH
13 PLANS.—The term ‘qualified health plan’ does not
14 include any health plan that includes coverage for
15 abortions (other than any abortion necessary to save
16 the life of the mother or any abortion with respect
17 to a pregnancy that is the result of an act of rape
18 or incest).”.

19 (2) EFFECTIVE DATE.—The amendments made
20 by this subsection shall apply to taxable years begin-
21 ning after December 31, 2017.

22 **SEC. 104. INDIVIDUAL MANDATE.**

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

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

3 (2) in paragraph (3)—

4 (A) by striking “\$695” in subparagraph
5 (A) and inserting “\$0”, and

6 (B) by striking subparagraph (D).

7 (b) EFFECTIVE DATE.—The amendments made by
8 this section shall apply to months beginning after Decem-
9 ber 31, 2015.

10 **SEC. 105. EMPLOYER MANDATE.**

11 (a) IN GENERAL.—

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

16 (2) Paragraph (1) of section 4980H(b) of the
17 Internal Revenue Code of 1986 is amended by in-
18 sserting “(\$0 in the case of months beginning after
19 December 31, 2015)” after “\$3,000”.

20 (b) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to months beginning after Decem-
22 ber 31, 2015.

1 **SEC. 106. STATE STABILITY AND INNOVATION PROGRAM.**

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

5 “(h) SHORT-TERM ASSISTANCE TO ADDRESS COV-
6 ERAGE AND ACCESS DISRUPTION AND PROVIDE SUPPORT
7 FOR STATES.—

8 “(1) APPROPRIATION.—There are authorized to
9 be appropriated, and are appropriated, out of monies
10 in the Treasury not otherwise obligated,
11 \$15,000,000,000 for each of calendar years 2018
12 and 2019, and \$10,000,000,000 for each of calendar
13 years 2020 and 2021, to the Administrator of the
14 Centers for Medicare & Medicaid Services (in this
15 subsection and subsection (i) referred to as the ‘Ad-
16 ministrator’) to fund arrangements with health in-
17 surance issuers to assist in the purchase of health
18 benefits coverage by addressing coverage and access
19 disruption and responding to urgent health care
20 needs within States. Funds appropriated under this
21 paragraph shall remain available until expended.

22 “(2) PARTICIPATION REQUIREMENTS.—

23 “(A) GUIDANCE.—Not later than 30 days
24 after the date of enactment of this subsection,
25 the Administrator shall issue guidance to health
26 insurance issuers regarding how to submit a no-

1 tice of intent to participate in the program es-
2 tablished under this subsection.

3 “(B) NOTICE OF INTENT TO PARTICI-
4 PATE.—To be eligible for funding under this
5 subsection, a health insurance issuer shall sub-
6 mit to the Administrator a notice of intent to
7 participate at such time (but, in the case of
8 funding for calendar year 2018, not later than
9 35 days after the date of enactment of this sub-
10 section and, in the case of funding for calendar
11 year 2019, 2020, 2021, 2022, 2023, 2024,
12 2025, or 2026, not later than March 31 of the
13 previous year) and in such form and manner as
14 specified by the Administrator and containing—

15 “(i) a certification that the health in-
16 surance issuer will use the funds in accord-
17 ance with the requirements of paragraph
18 (5); and

19 “(ii) such information as the Adminis-
20 trator may require to carry out this sub-
21 section.

22 “(3) PROCEDURE FOR DISTRIBUTION OF
23 FUNDS.—The Administrator shall determine an ap-
24 propriate procedure for providing and distributing
25 funds under this subsection that includes reserving

1 an amount equal to 1 percent of the amounts appro-
2 priated under paragraph (1) for a calendar year for
3 providing and distributing funds to health insurance
4 issuers in States where the cost of insurance pre-
5 miums are at least 75 percent higher than the na-
6 tional average.

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

12 “(5) USE OF FUNDS.—Funds provided to a
13 health insurance issuer under paragraph (1) or (6)
14 shall be subject to the requirements of paragraphs
15 (1)(D) and (7) of subsection (i) in the same manner
16 as such requirements apply to States receiving pay-
17 ments under subsection (i) and shall be used only
18 for the activities specified in paragraph (1)(A)(ii) of
19 subsection (i).

20 “(6) ADDITIONAL SUPPORT FOR STABILIZING
21 PREMIUMS AND PROMOTING CHOICE IN PLANS OF-
22 FERED IN THE INDIVIDUAL MARKET.—

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

1 Treasury not otherwise obligated,
2 \$10,000,000,000 for each of calendar years
3 2020 through 2026, for the purpose of funding
4 arrangements with health insurance issuers to
5 support the offering of qualified health plans in
6 States in which such issuers also offer coverage
7 in accordance with section 212(a) of the Better
8 Care Reconciliation Act.

9 “(B) USE OF FUNDS.—

10 “(i) IN GENERAL.—The Administrator
11 shall use amounts appropriated under sub-
12 paragraph (A) to establish a Federal fund
13 for the purpose of providing health insur-
14 ance coverage by making payments to
15 health insurance issuers that offer a plan
16 in accordance with section 212(a) of the
17 Better Care Reconciliation Act, to assist
18 such health insurance issuers in covering
19 high risk individuals enrolled in qualified
20 health plans through an Exchange in rat-
21 ing areas in which coverage is offered in
22 accordance with section 212(a) of such
23 Act. The Administrator shall determine an
24 appropriate procedure for making such
25 payments.

1 “(ii) PRIORITY USES.—In making
2 payments from the amounts appropriated
3 under subparagraph (A), the Adminis-
4 trator shall prioritize payments—

5 “(I) based on the percentage of
6 rating areas in the State that meet
7 the conditions in section 212(b) of
8 such Act; and

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

14 “(i) LONG-TERM STATE STABILITY AND INNOVATION
15 PROGRAM.—

16 “(1) APPLICATION AND CERTIFICATION RE-
17 QUIREMENTS.—To be eligible for an allotment of
18 funds under this subsection, a State shall submit to
19 the Administrator an application, not later than
20 March 31, 2018, in the case of allotments for cal-
21 endar year 2019, and not later than March 31 of
22 the previous year, in the case of allotments for any
23 subsequent calendar year) and in such form and
24 manner as specified by the Administrator, that con-
25 tains the following:

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

3 “(i) To establish or maintain a pro-
4 gram or mechanism to help high-risk indi-
5 viduals in the purchase of health benefits
6 coverage, including by reducing premium
7 costs for such individuals, who have or are
8 projected to have a high rate of utilization
9 of health services, as measured by cost,
10 and who do not have access to health in-
11 surance coverage offered through an em-
12 ployer, enroll in health insurance coverage
13 under a plan offered in the individual mar-
14 ket (within the meaning of section
15 5000A(f)(1)(C) of the Internal Revenue
16 Code of 1986).

17 “(ii) To establish or maintain a pro-
18 gram to enter into arrangements with
19 health insurance issuers to assist in the
20 purchase of health benefits coverage by
21 stabilizing premiums and promoting State
22 health insurance market participation and
23 choice in plans offered in the individual
24 market (within the meaning of section

1 5000A(f)(1)(C) of the Internal Revenue
2 Code of 1986).

3 “(iii) To provide payments for health
4 care providers for the provision of health
5 care services, as specified by the Adminis-
6 trator.

7 “(iv) To provide health insurance cov-
8 erage by funding assistance to reduce out-
9 of-pocket costs, such as copayments, coin-
10 surance, and deductibles, of individuals en-
11 rolled in plans offered in the individual
12 market (within the meaning of section
13 5000A(f)(1)(C) of the Internal Revenue
14 Code of 1986).

15 “(B) A certification that the State shall
16 make, from non-Federal funds, expenditures for
17 1 or more of the activities specified in subpara-
18 graph (A) in an amount that is not less than
19 the State percentage required for the year
20 under paragraph (5)(B)(ii).

21 “(C) A certification that the funds pro-
22 vided under this subsection shall only be used
23 for the activities specified in subparagraph (A).

24 “(D) A certification that none of the funds
25 provided under this subsection shall be used by

1 the State for an expenditure that is attributable
2 to an intergovernmental transfer, certified pub-
3 lic expenditure, or any other expenditure to fi-
4 nance the non-Federal share of expenditures re-
5 quired under any provision of law, including
6 under the State plans established under this
7 title and title XIX or under a waiver of such
8 plans.

9 “(E) Such other information as necessary
10 for the Administrator to carry out this sub-
11 section.

12 “(2) ELIGIBILITY.—Only the 50 States and the
13 District of Columbia shall be eligible for an allot-
14 ment and payments under this subsection and all
15 references in this subsection to a State shall be
16 treated as only referring to the 50 States and the
17 District of Columbia.

18 “(3) ONE-TIME APPLICATION.—If an applica-
19 tion of a State submitted under this subsection is
20 approved by the Administrator for a year, the appli-
21 cation shall be deemed to be approved by the Admin-
22 istrator for that year and each subsequent year
23 through December 31, 2026.

24 “(4) LONG-TERM STATE STABILITY AND INNO-
25 VATION ALLOTMENTS.—

1 “(A) APPROPRIATION; TOTAL ALLOT-
2 MENT.—For the purpose of providing allot-
3 ments to States under this subsection, there is
4 appropriated, out of any money in the Treasury
5 not otherwise appropriated—

6 “(i) for calendar year 2019,
7 \$8,000,000,000;

8 “(ii) for calendar year 2020,
9 \$29,000,000,000;

10 “(iii) for calendar year 2021,
11 \$29,000,000,000;

12 “(iv) for calendar year 2022,
13 \$33,200,000,000;

14 “(v) for calendar year 2023,
15 \$33,200,000,000;

16 “(vi) for calendar year 2024,
17 \$33,200,000,000;

18 “(vii) for calendar year 2025,
19 \$33,200,000,000; and

20 “(viii) for calendar year 2026,
21 \$33,200,000,000.

22 “(B) ALLOTMENTS.—

23 “(i) IN GENERAL.—In the case of a
24 State with an application approved under
25 this subsection with respect to a year, the

1 Administrator shall allot to the State, in
2 accordance with an allotment methodology
3 specified by the Administrator that ensures
4 that the spending requirements in para-
5 graphs (6) are met for the year and that
6 reserves an amount that is at least 1 per-
7 cent of the amount appropriated under
8 subparagraph (A) for a calendar year for
9 allotments to each State where the cost of
10 insurance premiums are at least 75 per-
11 cent higher than the national average,
12 from amounts appropriated for such year
13 under subparagraph (A), such amount as
14 specified by the Administrator with respect
15 to the State and application and year.

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

18 “(I) IN GENERAL.— In carrying
19 out clause (i), with respect to a year
20 (beginning with 2021), the Adminis-
21 trator shall, not later than March 31
22 of such year—

23 “(aa) determine the amount
24 of funds, if any, remaining un-

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

3 “(bb) if the Administrator
4 determines that any funds so re-
5 main from the previous year, re-
6 distribute such remaining funds
7 in accordance with an allotment
8 methodology specified by the Ad-
9 ministrator to States that have
10 submitted an application ap-
11 proved under this subsection for
12 the year.

13 “(II) APPLICABLE STATE PER-
14 CENTAGE.—The State percentage
15 specified for a year in paragraph
16 (5)(B)(ii) shall apply to funds redis-
17 tributed under subclause (I) in that
18 year.

19 “(C) AVAILABILITY OF ALLOTTED STATE
20 FUNDS.—

21 “(i) IN GENERAL.—Amounts allotted
22 to a State pursuant to subparagraph (B)(i)
23 for a year shall remain available for ex-
24 penditure by the State through the end of
25 the second succeeding year.

1 “(ii) AVAILABILITY OF AMOUNTS RE-
2 DISTRIBUTED.—Amounts redistributed to
3 a State under subparagraph (B)(ii) in a
4 year shall be available for expenditure by
5 the State through the end of the second
6 succeeding year.

7 “(5) PAYMENTS.—

8 “(A) ANNUAL PAYMENT OF ALLOT-
9 MENTS.—Subject to subparagraph (B), the Ad-
10 ministrators shall pay to each State that has an
11 application approved under this subsection for a
12 year, from the allotment determined under
13 paragraph (4)(B) for the State for the year, an
14 amount equal to the Federal percentage of the
15 State’s expenditures for the year.

16 “(B) STATE EXPENDITURES REQUIRED
17 BEGINNING 2022.—For purposes of subpara-
18 graph (A), the Federal percentage is equal to
19 100 percent reduced by the State percentage
20 for that year, and the State percentage is equal
21 to—

22 “(i) in the case of calendar year 2019,
23 0 percent;

24 “(ii) in the case of calendar year
25 2020, 0 percent;

1 “(iii) in the case of calendar year
2 2021, 0 percent;

3 “(iv) in the case of calendar year
4 2022, 7 percent;

5 “(v) in the case of calendar year
6 2023, 14 percent;

7 “(vi) in the case of calendar year
8 2024, 21 percent;

9 “(vii) in the case of calendar year
10 2025, 28 percent; and

11 “(viii) in the case of calendar year
12 2026, 35 percent.

13 “(C) ADVANCE PAYMENT; RETROSPECTIVE
14 ADJUSTMENT.—

15 “(i) IN GENERAL.—If the Adminis-
16 trator deems it appropriate, the Adminis-
17 trator shall make payments under this sub-
18 section for each year on the basis of ad-
19 vance estimates of expenditures submitted
20 by the State and such other investigation
21 as the Administrator shall find necessary,
22 and shall reduce or increase the payments
23 as necessary to adjust for any overpayment
24 or underpayment for prior years.

1 “(ii) MISUSE OF FUNDS.—If the Ad-
2 ministrators determines that a State is not
3 using funds paid to the State under this
4 subsection in a manner consistent with the
5 description provided by the State in its ap-
6 plication approved under paragraph (1),
7 the Administrator may withhold payments,
8 reduce payments, or recover previous pay-
9 ments to the State under this subsection
10 as the Administrator deems appropriate.

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

16 “(6) REQUIRED USES.—

17 “(A) PREMIUM STABILIZATION AND IN-
18 CENTIVES FOR INDIVIDUAL MARKET PARTICIPA-
19 TION.—In determining allotments for States
20 under this subsection for each of calendar years
21 2019, 2020, and 2021, the Administrator shall
22 ensure that at least \$5,000,000,000 of the
23 amounts appropriated for each such year under
24 paragraph (4)(A) are used by States for the
25 purposes described in paragraph (1)(A)(ii) and

1 in accordance with guidance issued by the Ad-
2 ministrator not later than 30 days after the
3 date of enactment of this subsection that speci-
4 fies the parameters for the use of funds for
5 such purposes.

6 “(B) ASSISTANCE WITH OUT-OF-POCKET
7 COSTS.—In determining allotments for States
8 under this subsection for each of calendar years
9 2020 through 2026, the Administrator shall en-
10 sure that at least \$15,000,000,000 of the
11 amounts appropriated for each of calendar
12 years 2020 and 2021 under paragraph (4)(A),
13 and at least \$14,000,000,000 of the amounts
14 appropriated for each of calendar years 2022
15 through 2026 under such paragraph, are used
16 by States for the purposes described in para-
17 graph (1)(A)(iv) and in accordance with guid-
18 ance issued by the Administrator not later than
19 September 1, 2019, that specifies the param-
20 eters for the use of funds for such purposes.

21 “(7) EXEMPTIONS.—Paragraphs (2), (3), (5),
22 (6), (8), (10), and (11) of subsection (c) do not
23 apply to payments under this subsection.”.

24 (b) OTHER TITLE XXI AMENDMENTS.—

1 (1) Section 2101 of such Act (42 U.S.C.
2 1397aa) is amended—

3 (A) in subsection (a), in the matter pre-
4 ceding paragraph (1), by striking “The pur-
5 pose” and inserting “Except with respect to
6 short-term assistance activities under section
7 2105(h) and the Long-Term State Stability and
8 Innovation Program established in section
9 2105(i), the purpose”; and

10 (B) in subsection (b), in the matter pre-
11 ceding paragraph (1), by inserting “subsection
12 (a) or (g) of” before “section 2105”.

13 (2) Section 2105(c)(1) of such Act (42 U.S.C.
14 1397ee(c)(1)) is amended by striking “and may not
15 include” and inserting “or to carry out short-term
16 assistance activities under subsection (h) or the
17 Long-Term State Stability and Innovation Program
18 established in subsection (i) and, except in the case
19 of funds made available under subsection (h) or (i),
20 may not include”.

21 (3) Section 2106(a)(1) of such Act (42 U.S.C.
22 1397ff(a)(1)) is amended by inserting “subsection
23 (a) or (g) of” before “section 2105”.

1 **SEC. 107. BETTER CARE RECONCILIATION IMPLEMENTA-**
2 **TION FUND.**

3 (a) IN GENERAL.—There is hereby established a Bet-
4 ter Care Reconciliation Implementation Fund (referred to
5 in this section as the “Fund”) within the Department of
6 Health and Human Services to provide for Federal admin-
7 istrative expenses in carrying out this Act.

8 (b) FUNDING.—There is appropriated to the Fund,
9 out of any funds in the Treasury not otherwise appro-
10 priated, \$500,000,000.

11 **SEC. 108. REPEAL OF THE TAX ON EMPLOYEE HEALTH IN-**
12 **SURANCE PREMIUMS AND HEALTH PLAN**
13 **BENEFITS.**

14 (a) IN GENERAL.—Chapter 43 of the Internal Rev-
15 enue Code of 1986 is amended by striking section 4980I.

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

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

1 **SEC. 109. REPEAL OF TAX ON OVER-THE-COUNTER MEDICA-**
2 **TIONS.**

3 (a) HSAs.—Subparagraph (A) of section 223(d)(2)
4 of the Internal Revenue Code of 1986 is amended by strik-
5 ing “Such term” and all that follows through the period.

6 (b) ARCHER MSAs.—Subparagraph (A) of section
7 220(d)(2) of the Internal Revenue Code of 1986 is amend-
8 ed by striking “Such term” and all that follows through
9 the period.

10 (c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS
11 AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Sec-
12 tion 106 of the Internal Revenue Code of 1986 is amended
13 by striking subsection (f).

14 (d) EFFECTIVE DATES.—

15 (1) DISTRIBUTIONS FROM SAVINGS AC-
16 COUNTS.—The amendments made by subsections (a)
17 and (b) shall apply to amounts paid with respect to
18 taxable years beginning after December 31, 2016.

19 (2) REIMBURSEMENTS.—The amendment made
20 by subsection (c) shall apply to expenses incurred
21 with respect to taxable years beginning after Decem-
22 ber 31, 2016.

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

24 (a) HSAs.—Section 223(f)(4)(A) of the Internal
25 Revenue Code of 1986 is amended by striking “20 per-
26 cent” and inserting “10 percent”.

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

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to distributions made after Decem-
6 ber 31, 2016.

7 **SEC. 111. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO**
8 **FLEXIBLE SPENDING ACCOUNTS.**

9 (a) IN GENERAL.—Section 125 of the Internal Rev-
10 enue Code of 1986 is amended by striking subsection (i).

11 (b) EFFECTIVE DATE.—The amendment made by
12 this section shall apply to plan years beginning after De-
13 cember 31, 2017.

14 **SEC. 112. REPEAL OF TAX ON PRESCRIPTION MEDICA-**
15 **TIONS.**

16 Subsection (j) of section 9008 of the Patient Protec-
17 tion and Affordable Care Act is amended to read as fol-
18 lows:

19 “(j) REPEAL.—This section shall apply to calendar
20 years beginning after December 31, 2010, and ending be-
21 fore January 1, 2018.”.

22 **SEC. 113. REPEAL OF MEDICAL DEVICE EXCISE TAX.**

23 Section 4191 of the Internal Revenue Code of 1986
24 is amended by adding at the end the following new sub-
25 section:

1 “(d) APPLICABILITY.—The tax imposed under sub-
2 section (a) shall not apply to sales after December 31,
3 2017.”.

4 **SEC. 114. REPEAL OF HEALTH INSURANCE TAX.**

5 Subsection (j) of section 9010 of the Patient Protec-
6 tion and Affordable Care Act is amended by striking “,
7 and” at the end of paragraph (1) and all that follows
8 through “2017”.

9 **SEC. 115. REPEAL OF ELIMINATION OF DEDUCTION FOR**
10 **EXPENSES ALLOCABLE TO MEDICARE PART D**
11 **SUBSIDY.**

12 (a) IN GENERAL.—Section 139A of the Internal Rev-
13 enue Code of 1986 is amended by adding at the end the
14 following new sentence: “This section shall not be taken
15 into account for purposes of determining whether any de-
16 duction is allowable with respect to any cost taken into
17 account in determining such payment.”.

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

21 **SEC. 116. REPEAL OF CHRONIC CARE TAX.**

22 (a) IN GENERAL.—Subsection (a) of section 213 of
23 the Internal Revenue Code of 1986 is amended by striking
24 “10 percent” and inserting “7.5 percent”.

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

4 **SEC. 117. REPEAL OF TANNING TAX.**

5 (a) IN GENERAL.—The Internal Revenue Code of
6 1986 is amended by striking chapter 49.

7 (b) EFFECTIVE DATE.—The amendment made by
8 this section shall apply to services performed after Sep-
9 tember 30, 2017.

10 **SEC. 118. PURCHASE OF INSURANCE FROM HEALTH SAV-**
11 **INGS ACCOUNT.**

12 (a) PURCHASE OF HIGH DEDUCTIBLE HEALTH
13 PLANS.—

14 (1) IN GENERAL.—Paragraph (2) of section
15 223(d) of the Internal Revenue Code of 1986, as
16 amended by section 109(a), is amended—

17 (A) by striking “and any dependent (as de-
18 fined in section 152, determined without regard
19 to subsections (b)(1), (b)(2), and (d)(1)(B)
20 thereof) of such individual” in subparagraph
21 (A) and inserting “any dependent (as defined in
22 section 152, determined without regard to sub-
23 sections (b)(1), (b)(2), and (d)(1)(B) thereof)
24 of such individual, and any child (as defined in
25 section 152(f)(1)) of such individual who has

1 not attained the age of 27 before the end of
2 such individual's taxable year",

3 (B) by striking subparagraph (B) and in-
4 serting the following:

5 "(B) HEALTH INSURANCE MAY NOT BE
6 PURCHASED FROM ACCOUNT.—Except as pro-
7 vided in subparagraph (C), subparagraph (A)
8 shall not apply to any payment for insurance.",
9 and

10 (C) by striking "or" at the end of subpara-
11 graph (C)(iii), by striking the period at the end
12 of subparagraph (C)(iv) and inserting ", or",
13 and by adding at the end the following:

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

17 "(I) any amount allowable as a
18 credit under section 36B for the tax-
19 able year with respect to such cov-
20 erage,

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

24 "(III) any amount excludable
25 from gross income with respect to

1 such coverage under section 106 (in-
2 cluding by reason of section 125) or
3 402(l).”.

4 (2) EFFECTIVE DATE.—The amendments made
5 by this subsection shall apply with respect to
6 amounts paid for expenses incurred for, and dis-
7 tributions made for, coverage under a high deduct-
8 ible health plan beginning after December 31, 2017.

9 (b) CONSUMER FREEDOM PLANS.—

10 (1) IN GENERAL.—Section 223(d)(2)(C) of the
11 Internal Revenue Code of 1986, as amended by sub-
12 section (a) and section 122, is amended—

13 (A) by striking “or” at the end of clause
14 (iv), by striking the period at the end of clause
15 (v), and by adding at the end the following:

16 “(vi) any plan which—

17 “(I) is offered by a health insur-
18 ance issuer which meets the condi-
19 tions described in section 212(b) of
20 the Better Care Reconciliation Act of
21 2017 for the plan year, and

22 “(II) would not be permitted to
23 be offered in the market but for such
24 section.”, and

1 (B) by inserting “or (vi)” after “clause
2 (v)” in the last sentence thereof.

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

6 **SEC. 119. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAV-**
7 **INGS ACCOUNT INCREASED TO AMOUNT OF**
8 **DEDUCTIBLE AND OUT-OF-POCKET LIMITA-**
9 **TION.**

10 (a) SELF-ONLY COVERAGE.—Section 223(b)(2)(A)
11 of the Internal Revenue Code of 1986 is amended by strik-
12 ing “\$2,250” and inserting “the amount in effect under
13 subsection (c)(2)(A)(ii)(I)”.

14 (b) FAMILY COVERAGE.—Section 223(b)(2)(B) of
15 such Code is amended by striking “\$4,500” and inserting
16 “the amount in effect under subsection (c)(2)(A)(ii)(II)”.

17 (c) COST-OF-LIVING ADJUSTMENT.—Section
18 223(g)(1) of such Code is amended—

19 (1) by striking “subsections (b)(2) and” both
20 places it appears and inserting “subsection”, and

21 (2) in subparagraph (B), by striking “deter-
22 mined by” and all that follows through “‘calendar
23 year 2003’.” and inserting “determined by sub-
24 stituting ‘calendar year 2003’ for ‘calendar year
25 1992’ in subparagraph (B) thereof.”.

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

4 **SEC. 120. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CON-**
5 **TRIBUTIONS TO THE SAME HEALTH SAVINGS**
6 **ACCOUNT.**

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

9 “(5) SPECIAL RULE FOR MARRIED INDIVIDUALS
10 WITH FAMILY COVERAGE.—

11 “(A) IN GENERAL.—In the case of individ-
12 uals who are married to each other, if both
13 spouses are eligible individuals and either
14 spouse has family coverage under a high de-
15 ductible health plan as of the first day of any
16 month—

17 “(i) the limitation under paragraph
18 (1) shall be applied by not taking into ac-
19 count any other high deductible health
20 plan coverage of either spouse (and if such
21 spouses both have family coverage under
22 separate high deductible health plans, only
23 one such coverage shall be taken into ac-
24 count),

1 “(ii) such limitation (after application
2 of clause (i)) shall be reduced by the ag-
3 gregate amount paid to Archer MSAs of
4 such spouses for the taxable year, and

5 “(iii) such limitation (after application
6 of clauses (i) and (ii)) shall be divided
7 equally between such spouses unless they
8 agree on a different division.

9 “(B) TREATMENT OF ADDITIONAL CON-
10 TRIBUTION AMOUNTS.—If both spouses referred
11 to in subparagraph (A) have attained age 55
12 before the close of the taxable year, the limita-
13 tion referred to in subparagraph (A)(iii) which
14 is subject to division between the spouses shall
15 include the additional contribution amounts de-
16 termined under paragraph (3) for both spouses.
17 In any other case, any additional contribution
18 amount determined under paragraph (3) shall
19 not be taken into account under subparagraph
20 (A)(iii) and shall not be subject to division be-
21 tween the spouses.”.

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

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

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

7 “(D) **TREATMENT OF CERTAIN MEDICAL**
8 **EXPENSES INCURRED BEFORE ESTABLISHMENT**
9 **OF ACCOUNT.**—If a health savings account is
10 established during the 60-day period beginning
11 on the date that coverage of the account bene-
12 ficiary under a high deductible health plan be-
13 gins, then, solely for purposes of determining
14 whether an amount paid is used for a qualified
15 medical expense, such account shall be treated
16 as having been established on the date that
17 such coverage begins.”.

18 (b) **EFFECTIVE DATE.**—The amendment made by
19 this subsection shall apply with respect to coverage under
20 a high deductible health plan beginning after December
21 31, 2017.

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

4 (a) IN GENERAL.—Subparagraph (C) of section
5 223(d)(2) of the Internal Revenue Code of 1986 is amend-
6 ed by adding at the end the following flush sentence:

7 “A high deductible health plan shall not be
8 treated as described in clause (v) if such plan
9 includes coverage for abortions (other than any
10 abortion necessary to save the life of the mother
11 or any abortion with respect to a pregnancy
12 that is the result of an act of rape or incest).”.

13 (b) EFFECTIVE DATE.—The amendment made by
14 this section shall apply with respect to coverage under a
15 high deductible health plan beginning after December 31,
16 2017.

17 **SEC. 123. FEDERAL PAYMENTS TO STATES.**

18 (a) IN GENERAL.—Notwithstanding section 504(a),
19 1902(a)(23), 1903(a), 2002, 2005(a)(4), 2102(a)(7), or
20 2105(a)(1) of the Social Security Act (42 U.S.C. 704(a),
21 1396a(a)(23), 1396b(a), 1397a, 1397d(a)(4),
22 1397bb(a)(7), 1397ee(a)(1)), or the terms of any Med-
23 icaid waiver in effect on the date of enactment of this Act
24 that is approved under section 1115 or 1915 of the Social
25 Security Act (42 U.S.C. 1315, 1396n), for the 1-year pe-
26 riod beginning on the date of enactment of this Act, no

1 Federal funds provided from a program referred to in this
2 subsection that is considered direct spending for any year
3 may be made available to a State for payments to a pro-
4 hibited entity, whether made directly to the prohibited en-
5 tity or through a managed care organization under con-
6 tract with the State.

7 (b) DEFINITIONS.—In this section:

8 (1) PROHIBITED ENTITY.—The term “prohib-
9 ited entity” means an entity, including its affiliates,
10 subsidiaries, successors, and clinics—

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

13 (i) is an organization described in sec-
14 tion 501(c)(3) of the Internal Revenue
15 Code of 1986 and exempt from tax under
16 section 501(a) of such Code;

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

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

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

3 (II) in the case where a woman
4 suffers from a physical disorder, phys-
5 ical injury, or physical illness that
6 would, as certified by a physician,
7 place the woman in danger of death
8 unless an abortion is performed, in-
9 cluding a life-endangering physical
10 condition caused by or arising from
11 the pregnancy itself; and

12 (B) for which the total amount of Federal
13 and State expenditures under the Medicaid pro-
14 gram under title XIX of the Social Security Act
15 in fiscal year 2014 made directly to the entity
16 and to any affiliates, subsidiaries, successors, or
17 clinics of the entity, or made to the entity and
18 to any affiliates, subsidiaries, successors, or
19 clinics of the entity as part of a nationwide
20 health care provider network, exceeded
21 \$350,000,000.

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

1 **SEC. 124. MEDICAID PROVISIONS.**

2 The Social Security Act is amended—

3 (1) in section 1902(a)(47)(B) (42 U.S.C.
4 1396a(a)(47)(B)), by inserting “and provided that
5 any such election shall cease to be effective on Janu-
6 ary 1, 2020, and no such election shall be made
7 after that date” before the semicolon at the end;

8 (2) in section 1915(k)(2) (42 U.S.C.
9 1396n(k)(2)), by striking “during the period de-
10 scribed in paragraph (1)” and inserting “on or after
11 the date referred to in paragraph (1) and before
12 January 1, 2020”; and

13 (3) in section 1920(e) (42 U.S.C. 1396r–1(e)),
14 by striking “under clause (i)(VIII), clause (i)(IX), or
15 clause (ii)(XX) of subsection (a)(10)(A)” and insert-
16 ing “under clause (i)(VIII) or clause (ii)(XX) of sec-
17 tion 1902(a)(10)(A) before January 1, 2020, section
18 1902(a)(10)(A)(i)(IX),”.

19 **SEC. 125. MEDICAID EXPANSION.**

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

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

23 (A) in subsection (a)(10)(A)—

24 (i) in clause (i)(VIII), by inserting
25 “and ending December 31, 2019,” after
26 “2014,”; and

1 (ii) in clause (ii), in subclause (XX),
2 by inserting “and ending December 31,
3 2017,” after “2014,” and by adding at
4 the end the following new subclause:

5 “(XXIII) beginning January 1, 2020,
6 who are expansion enrollees (as defined in
7 subsection (nn)(1));” and

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

10 “(nn) EXPANSION ENROLLEES.—

11 “(1) IN GENERAL.—In this title, the term ‘ex-
12 pansion enrollee’ means an individual—

13 “(A) who is under 65 years of age;

14 “(B) who is not pregnant;

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

18 “(D) who is not described in any of sub-
19 clauses (I) through (VII) of subsection
20 (a)(10)(A)(i); and

21 “(E) whose income (as determined under
22 subsection (e)(14)) does not exceed 133 percent
23 of the poverty line (as defined in section
24 2110(c)(5)) applicable to a family of the size in-
25 volved.

1 “(2) APPLICATION OF RELATED PROVISIONS.—

2 Any reference in subsection (a)(10)(G), (k), or (gg)
3 of this section or in section 1903, 1905(a), 1920(e),
4 or 1937(a)(1)(B) to individuals described in sub-
5 clause (VIII) of subsection (a)(10)(A)(i) shall be
6 deemed to include a reference to expansion enroll-
7 ees.”; and

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

9 (A) in subsection (y)(1)—

10 (i) in the matter preceding subpara-
11 graph (A), by striking “, with respect to”
12 and all that follows through “shall be equal
13 to” and inserting “and that has elected to
14 cover newly eligible individuals before
15 March 1, 2017, with respect to amounts
16 expended by such State before January 1,
17 2020, for medical assistance for newly eli-
18 gible individuals described in subclause
19 (VIII) of section 1902(a)(10)(A)(i), and,
20 with respect to amounts expended by such
21 State after December 31, 2019, and before
22 January 1, 2024, for medical assistance
23 for expansion enrollees (as defined in sec-
24 tion 1902(m)(1)), shall be equal to the
25 higher of the percentage otherwise deter-

1 mined for the State and year under sub-
2 section (b) (without regard to this sub-
3 section) and”;

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

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

8 “(E) 90 percent for calendar quarters in
9 2020;

10 “(F) 85 percent for calendar quarters in
11 2021;

12 “(G) 80 percent for calendar quarters in
13 2022; and

14 “(H) 75 percent for calendar quarters in
15 2023.”; and

16 (iv) by adding after and below sub-
17 paragraph (H) (as added by clause (iii)),
18 the following flush sentence:

19 “The Federal medical assistance percentage deter-
20 mined for a State and year under subsection (b)
21 shall apply to expenditures for medical assistance to
22 newly eligible individuals (as so described) and ex-
23 pansion enrollees (as so defined), in the case of a
24 State that has elected to cover newly eligible individ-
25 uals before March 1, 2017, for calendar quarters

1 after 2023, and, in the case of any other State, for
2 calendar quarters (or portions of calendar quarters)
3 after February 28, 2017.”; and

4 (B) in subsection (z)(2)—

5 (i) in subparagraph (A)—

6 (I) by inserting “through 2023”
7 after “each year thereafter”; and

8 (II) by striking “shall be equal
9 to” and inserting “and, for periods
10 after December 31, 2019 and before
11 January 1, 2024, who are expansion
12 enrollees (as defined in section
13 1902(nn)(1)) shall be equal to the
14 higher of the percentage otherwise de-
15 termined for the State and year under
16 subsection (b) (without regard to this
17 subsection) and”; and

18 (ii) in subparagraph (B)(ii)—

19 (I) in subclause (III), by adding
20 “and” at the end; and

21 (II) by striking subclauses (IV),
22 (V), and (VI) and inserting the fol-
23 lowing new subclause:

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

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

6 **SEC. 126. RESTORING FAIRNESS IN DSH ALLOTMENTS.**

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

10 “(C) NON-EXPANSION STATES.—

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

14 “(I) subparagraph (A) shall not
15 apply to the DSH allotment for such
16 State and fiscal year; and

17 “(II) the DSH allotment for the
18 State for fiscal year 2020 (including
19 for a non-expansion State that has a
20 DSH allotment determined under
21 paragraph (6)) shall be increased by
22 the amount calculated according to
23 clause (iii).

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

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

5 “(iii) AMOUNT CALCULATED.—For
6 purposes of clause (i)(II), the amount cal-
7 culated according to this clause for a non-
8 expansion State is the following:

9 “(I) For each State, the Sec-
10 retary shall calculate a ratio equal to
11 the State’s fiscal year 2016 DSH al-
12 lotment divided by the number of un-
13 insured individuals in the State for
14 such fiscal year (determined on the
15 basis of the most recent information
16 available from the Bureau of the Cen-
17 sus).

18 “(II) The Secretary shall identify
19 the States whose ratio as so deter-
20 mined is below the national average of
21 such ratio for all States.

22 “(III) The amount calculated
23 pursuant to this clause is an amount
24 that, if added to the State’s fiscal
25 year 2016 DSH allotment, would in-

1 crease the ratio calculated pursuant to
2 subclause (I) up to the national aver-
3 age for all States.

4 “(iv) DISREGARD OF INCREASE.—The
5 DSH allotment for a non-expansion State
6 for the second, third, and fourth quarters
7 of fiscal year 2024 and fiscal years there-
8 after shall be determined as if there had
9 been no increase in the State’s DSH allot-
10 ment for fiscal year 2020 under clause
11 (i)(II).

12 “(v) NON-EXPANSION AND EXPANSION
13 STATE DEFINED.—In this subparagraph:

14 “(I) The term ‘expansion State’
15 means with respect to a fiscal year, a
16 State that, on or after January 1,
17 2021, provides eligibility under sub-
18 clause (XXIII) of section
19 1902(a)(10)(A)(ii) for medical assist-
20 ance under this title (or provides eligi-
21 bility for individuals described in such
22 subclause under a waiver of the State
23 plan approved under section 1115).

24 “(II) The term ‘non-expansion
25 State’ means, with respect to a fiscal

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

3 “(aa) in the case of a State
4 that provides eligibility under
5 clause (i)(VIII), (ii)(XX), or
6 (ii)(XXIII) of section
7 1902(a)(10)(A) for medical as-
8 sistance under this title (or pro-
9 vides eligibility for individuals de-
10 scribed in any of such clauses
11 under a waiver of the State plan
12 approved under section 1115) for
13 any quarter occurring during the
14 period that begins on October 1,
15 2017, and ends on December 31,
16 2020 the State shall be treated
17 as a non-expansion State for pur-
18 poses of clause (i) only for quar-
19 ters beginning on or after the
20 first day of the first month for
21 which the State no longer pro-
22 vides such eligibility; and

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

1 pansion State on January 1,
2 2021, but which provided such
3 eligibility on January 1, 2020,
4 the DSH allotment for such
5 State for each of fiscal years
6 2021 through 2023 and the first
7 fiscal quarter of 2024 shall be
8 determined as if the State’s DSH
9 allotment for fiscal year 2020
10 had been increased under clause
11 (i)(II).”.

12 **SEC. 127. REDUCING STATE MEDICAID COSTS.**

13 (a) IN GENERAL.—

14 (1) STATE PLAN REQUIREMENTS.—Section
15 1902(a)(34) of the Social Security Act (42 U.S.C.
16 1396a(a)(34)) is amended by striking “in or after
17 the third month” and all that follows through “indi-
18 vidual)” and inserting “in or after the month in
19 which the individual (or, in the case of a deceased
20 individual, another individual acting on the individ-
21 ual’s behalf) made application (or, in the case of an
22 individual who is 65 years of age or older or who is
23 eligible for medical assistance under the plan on the
24 basis of being blind or disabled, in or after the third
25 month before such month)”.

1 (2) DEFINITION OF MEDICAL ASSISTANCE.—
2 Section 1905(a) of the Social Security Act (42
3 U.S.C. 1396d(a)) is amended by striking “in or
4 after the third month before the month in which the
5 recipient makes application for assistance” and in-
6 serting “in or after the month in which the recipient
7 makes application for assistance, or, in the case of
8 a recipient who is 65 years of age or older or who
9 is eligible for medical assistance on the basis of
10 being blind or disabled at the time application is
11 made, in or after the third month before the month
12 in which the recipient makes application for assist-
13 ance,”.

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

19 **SEC. 128. PROVIDING SAFETY NET FUNDING FOR NON-EX-**
20 **PANSION STATES.**

21 Title XIX of the Social Security Act is amended by
22 inserting after section 1923 (42 U.S.C. 1396r–4) the fol-
23 lowing new section:

1 “ADJUSTMENT IN PAYMENT FOR SERVICES OF SAFETY
2 NET PROVIDERS IN NON-EXPANSION STATES
3 “SEC. 1923A. (a) IN GENERAL.—Subject to the limi-
4 tations of this section, for each year during the period be-
5 ginning with fiscal year 2018 and ending with fiscal year
6 2022, each State that is one of the 50 States or the Dis-
7 trict of Columbia and that, as of July 1 of the preceding
8 fiscal year, did not provide for eligibility under clause
9 (i)(VIII), (ii)(XX), or (ii)(XXIII) of section
10 1902(a)(10)(A) for medical assistance under this title (or
11 a waiver of the State plan approved under section 1115)
12 (each such State or District referred to in this section for
13 the fiscal year as a ‘non-expansion State’) may adjust the
14 payment amounts otherwise provided under the State plan
15 under this title (or a waiver of such plan) to health care
16 providers that provide health care services to individuals
17 enrolled under this title (in this section referred to as ‘eli-
18 gible providers’) so long as the payment adjustment to
19 such an eligible provider does not exceed the provider’s
20 costs in furnishing health care services (as determined by
21 the Secretary and net of payments under this title, other
22 than under this section, and by uninsured patients) to in-
23 dividuals who either are eligible for medical assistance
24 under the State plan (or under a waiver of such plan) or

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

3 “(b) INCREASE IN APPLICABLE FMAP.—Notwith-
4 standing section 1905(b), the Federal medical assistance
5 percentage applicable with respect to expenditures attrib-
6 utable to a payment adjustment under subsection (a) for
7 which payment is permitted under subsection (c) shall be
8 equal to—

9 “(1) 100 percent for calendar quarters in fiscal
10 years 2018, 2019, 2020, and 2021; and

11 “(2) 95 percent for calendar quarters in fiscal
12 year 2022.

13 “(c) ANNUAL ALLOTMENT LIMITATION.—Payment
14 under section 1903(a) shall not be made to a State with
15 respect to any payment adjustment made under this sec-
16 tion for all calendar quarters in a fiscal year in excess
17 of the product of \$2,000,000,000 multiplied by the ratio
18 of—

19 “(1) the population of the State with income
20 below 138 percent of the poverty line in 2015 (as de-
21 termined based the table entitled ‘Health Insurance
22 Coverage Status and Type by Ratio of Income to
23 Poverty Level in the Past 12 Months by Age’ for the
24 universe of the civilian noninstitutionalized popu-
25 lation for whom poverty status is determined based

1 on the 2015 American Community Survey 1–Year
2 Estimates, as published by the Bureau of the Cen-
3 sus), to

4 “(2) the sum of the populations under para-
5 graph (1) for all non-expansion States.

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

12 **SEC. 129. ELIGIBILITY REDETERMINATIONS.**

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

17 “(J) FREQUENCY OF ELIGIBILITY REDE-
18 TERMINATIONS.—Beginning on October 1,
19 2017, and notwithstanding subparagraph (H),
20 in the case of an individual whose eligibility for
21 medical assistance under the State plan under
22 this title (or a waiver of such plan) is deter-
23 mined based on the application of modified ad-
24 justed gross income under subparagraph (A)
25 and who is so eligible on the basis of clause

1 (i)(VIII), (ii)(XX), or (ii)(XXIII) of subsection
2 (a)(10)(A), at the option of the State, the State
3 plan may provide that the individual's eligibility
4 shall be redetermined every 6 months (or such
5 shorter number of months as the State may
6 elect).”.

7 (b) INCREASED ADMINISTRATIVE MATCHING PER-
8 CENTAGE.—For each calendar quarter during the period
9 beginning on October 1, 2017, and ending on December
10 31, 2019, the Federal matching percentage otherwise ap-
11 plicable under section 1903(a) of the Social Security Act
12 (42 U.S.C. 1396b(a)) with respect to State expenditures
13 during such quarter that are attributable to meeting the
14 requirement of section 1902(e)(14) (relating to determina-
15 tions of eligibility using modified adjusted gross income)
16 of such Act shall be increased by 5 percentage points with
17 respect to State expenditures attributable to activities car-
18 ried out by the State (and approved by the Secretary) to
19 exercise the option described in subparagraph (J) of such
20 section (relating to eligibility redeterminations made on a
21 6-month or shorter basis) (as added by subsection (a)) to
22 increase the frequency of eligibility redeterminations.

1 **SEC. 130. OPTIONAL WORK REQUIREMENT FOR NON-**
2 **DISABLED, NONELDERLY, NONPREGNANT IN-**
3 **DIVIDUALS.**

4 (a) IN GENERAL.—Section 1902 of the Social Secu-
5 rity Act (42 U.S.C. 1396a), as previously amended, is fur-
6 ther amended by adding at the end the following new sub-
7 section:

8 “(00) OPTIONAL WORK REQUIREMENT FOR NON-
9 DISABLED, NONELDERLY, NONPREGNANT INDIVID-
10 UALS.—

11 “(1) IN GENERAL.—Beginning October 1,
12 2017, subject to paragraph (3), a State may elect to
13 condition medical assistance to a nondisabled, non-
14 elderly, nonpregnant individual under this title upon
15 such an individual’s satisfaction of a work require-
16 ment (as defined in paragraph (2)).

17 “(2) WORK REQUIREMENT DEFINED.—In this
18 section, the term ‘work requirement’ means, with re-
19 spect to an individual, the individual’s participation
20 in work activities (as defined in section 407(d)) for
21 such period of time as determined by the State, and
22 as directed and administered by the State.

23 “(3) REQUIRED EXCEPTIONS.—States admin-
24 istering a work requirement under this subsection
25 may not apply such requirement to—

1 “(A) a woman during pregnancy through
2 the end of the month in which the 60-day pe-
3 riod (beginning on the last day of her preg-
4 nancy) ends;

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

7 “(C) an individual who is the only parent
8 or caretaker relative in the family of a child
9 who has not attained 6 years of age or who is
10 the only parent or caretaker of a child with dis-
11 abilities; or

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

15 “(i) maintains satisfactory attendance
16 at secondary school or the equivalent; or

17 “(ii) participates in education directly
18 related to employment.”.

19 (b) INCREASE IN MATCHING RATE FOR IMPLEMEN-
20 TATION.—Section 1903 of the Social Security Act (42
21 U.S.C. 1396b) is amended by adding at the end the fol-
22 lowing:

23 “(aa) The Federal matching percentage otherwise ap-
24 plicable under subsection (a) with respect to State admin-
25 istrative expenditures during a calendar quarter for which

1 the State receives payment under such subsection shall,
2 in addition to any other increase to such Federal matching
3 percentage, be increased for such calendar quarter by 5
4 percentage points with respect to State expenditures at-
5 tributable to activities carried out by the State (and ap-
6 proved by the Secretary) to implement subsection (oo) of
7 section 1902.”.

8 **SEC. 131. PROVIDER TAXES.**

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

12 “(iii) For purposes of clause (i), a de-
13 termination of the existence of an indirect
14 guarantee shall be made under paragraph
15 (3)(i) of section 433.68(f) of title 42, Code
16 of Federal Regulations, as in effect on
17 June 1, 2017, except that—

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

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

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

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

7 “(V) for fiscal year 2025 and
8 each subsequent fiscal year, ‘5 per-
9 cent’ shall be substituted for ‘6 per-
10 cent’ each place it appears.”.

11 **SEC. 132. PER CAPITA ALLOTMENT FOR MEDICAL ASSIST-**
12 **ANCE.**

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

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

16 (A) in subsection (a), in the matter before
17 paragraph (1), by inserting “and section
18 1903A(a)” after “except as otherwise provided
19 in this section”; and

20 (B) in subsection (d)(1), by striking “to
21 which” and inserting “to which, subject to sec-
22 tion 1903A(a),”; and

23 (2) by inserting after such section 1903 the fol-
24 lowing new section:

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

3 “(a) APPLICATION OF PER CAPITA CAP ON PAY-
4 MENTS FOR MEDICAL ASSISTANCE EXPENDITURES.—

5 “(1) IN GENERAL.—If a State which is one of
6 the 50 States or the District of Columbia has excess
7 aggregate medical assistance expenditures (as de-
8 fined in paragraph (2)) for a fiscal year (beginning
9 with fiscal year 2020), the amount of payment to
10 the State under section 1903(a)(1) for each quarter
11 in the following fiscal year shall be reduced by $\frac{1}{4}$ of
12 the excess aggregate medical assistance payments
13 (as defined in paragraph (3)) for that previous fiscal
14 year. In this section, the term ‘State’ means only the
15 50 States and the District of Columbia.

16 “(2) EXCESS AGGREGATE MEDICAL ASSISTANCE
17 EXPENDITURES.—In this subsection, the term ‘ex-
18 cess aggregate medical assistance expenditures’
19 means, for a State for a fiscal year, the amount (if
20 any) by which—

21 “(A) the amount of the adjusted total med-
22 ical assistance expenditures (as defined in sub-
23 section (b)(1)) for the State and fiscal year; ex-
24 ceeds

1 “(B) the amount of the target total med-
2 ical assistance expenditures (as defined in sub-
3 section (c)) for the State and fiscal year.

4 “(3) EXCESS AGGREGATE MEDICAL ASSISTANCE
5 PAYMENTS.—In this subsection, the term ‘excess ag-
6 gregate medical assistance payments’ means, for a
7 State for a fiscal year, the product of—

8 “(A) the excess aggregate medical assist-
9 ance expenditures (as defined in paragraph (2))
10 for the State for the fiscal year; and

11 “(B) the Federal average medical assist-
12 ance matching percentage (as defined in para-
13 graph (4)) for the State for the fiscal year.

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

19 “(A) the amount of the Federal payments
20 that would be made to the State under section
21 1903(a)(1) for medical assistance expenditures
22 for calendar quarters in the fiscal year if para-
23 graph (1) did not apply; to

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

1 “(5) PER CAPITA BASE PERIOD.—

2 “(A) IN GENERAL.—In this section, the
3 term ‘per capita base period’ means, with re-
4 spect to a State, a period of 8 (or, in the case
5 of a State selecting a period under subpara-
6 graph (D), not less than 4) consecutive fiscal
7 quarters selected by the State.

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

11 “(C) PARAMETERS.—In selecting a per
12 capita base period under this paragraph, a
13 State shall—

14 “(i) only select a period of 8 (or, in
15 the case of a State selecting a base period
16 under subparagraph (D), not less than 4)
17 consecutive fiscal quarters for which all the
18 data necessary to make determinations re-
19 quired under this section is available, as
20 determined by the Secretary; and

21 “(ii) shall not select any period of 8
22 (or, in the case of a State selecting a base
23 period under subparagraph (D), not less
24 than 4) consecutive fiscal quarters that be-
25 gins with a fiscal quarter earlier than the

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

4 “(D) BASE PERIOD FOR LATE-EXPANDING
5 STATES.—

6 “(i) IN GENERAL.—In the case of a
7 State that did not provide for medical as-
8 sistance for the 1903A enrollee category
9 described in subsection (e)(2)(D) as of the
10 first day of the fourth fiscal quarter of fis-
11 cal year 2015 but which provided for such
12 assistance for such category in a subse-
13 quent fiscal quarter that is not later than
14 the fourth quarter of fiscal year 2016, the
15 State may select a per capita base period
16 that is less than 8 consecutive fiscal quar-
17 ters, but in no case shall the period se-
18 lected be less than 4 consecutive fiscal
19 quarters.

20 “(ii) APPLICATION OF OTHER RE-
21 QUIREMENTS.—Except for the requirement
22 that a per capita base period be a period
23 of 8 consecutive fiscal quarters, all other
24 requirements of this paragraph shall apply

1 to a per capita base period selected under
2 this subparagraph.

3 “(iii) APPLICATION OF BASE PERIOD
4 ADJUSTMENTS.—The adjustments to
5 amounts for per capita base periods re-
6 quired under subsections (b)(5) and
7 (d)(4)(E) shall be applied to amounts for
8 per capita base periods selected under this
9 subparagraph by substituting ‘divided by
10 the ratio that the number of quarters in
11 the base period bears to 4’ for ‘divided by
12 2’.

13 “(E) ADJUSTMENT BY THE SECRETARY.—
14 If the Secretary determines that a State took
15 actions after the date of enactment of this sec-
16 tion (including making retroactive adjustments
17 to supplemental payment data in a manner that
18 affects a fiscal quarter in the per capita base
19 period) to diminish the quality of the data from
20 the per capita base period used to make deter-
21 minations under this section, the Secretary may
22 adjust the data as the Secretary deems appro-
23 priate.

1 “(b) ADJUSTED TOTAL MEDICAL ASSISTANCE EX-
2 PENDING.—Subject to subsection (g), the following
3 shall apply:

4 “(1) IN GENERAL.—In this section, the term
5 ‘adjusted total medical assistance expenditures’
6 means, for a State—

7 “(A) for the State’s per capita base period
8 (as defined in subsection (a)(5)), the product
9 of—

10 “(i) the amount of the medical assist-
11 ance expenditures (as defined in paragraph
12 (2) and adjusted under paragraph (5)) for
13 the State and period, reduced by the
14 amount of any excluded expenditures (as
15 defined in paragraph (3) and adjusted
16 under paragraph (5)) for the State and pe-
17 riod otherwise included in such medical as-
18 sistance expenditures; and

19 “(ii) the 1903A base period popu-
20 lation percentage (as defined in paragraph
21 (4)) for the State; or

22 “(B) for fiscal year 2019 or a subsequent
23 fiscal year, the amount of the medical assist-
24 ance expenditures (as defined in paragraph (2))
25 for the State and fiscal year that is attributable

1 to 1903A enrollees, reduced by the amount of
2 any excluded expenditures (as defined in para-
3 graph (3)) for the State and fiscal year other-
4 wise included in such medical assistance ex-
5 penditures and includes non-DSH supplemental
6 payments (as defined in subsection
7 (d)(4)(A)(ii)) and payments described in sub-
8 section (d)(4)(A)(iii) but shall not be construed
9 as including any expenditures attributable to
10 the program under section 1928 (relating to
11 State pediatric vaccine distribution programs).
12 In applying subparagraph (B), non-DSH sup-
13 plemental payments (as defined in subsection
14 (d)(4)(A)(ii)) and payments described in sub-
15 section (d)(4)(A)(iii) shall be treated as fully at-
16 tributable to 1903A enrollees.

17 “(2) MEDICAL ASSISTANCE EXPENDITURES.—

18 In this section, the term ‘medical assistance expendi-
19 tures’ means, for a State and fiscal year or per cap-
20 ita base period, the medical assistance payments as
21 reported by medical service category on the Form
22 CMS-64 quarterly expense report (or successor to
23 such a report form, and including enrollment data
24 and subsequent adjustments to any such report, in
25 this section referred to collectively as a ‘CMS-64 re-

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

5 “(3) EXCLUDED EXPENDITURES.—In this sec-
6 tion, the term ‘excluded expenditures’ means, for a
7 State and fiscal year or per capita base period, ex-
8 penditures under the State plan (or under a waiver
9 of such plan) that are attributable to any of the fol-
10 lowing:

11 “(A) DSH.—Payment adjustments made
12 for disproportionate share hospitals under sec-
13 tion 1923.

14 “(B) MEDICARE COST-SHARING.—Pay-
15 ments made for medicare cost-sharing (as de-
16 fined in section 1905(p)(3)).

17 “(C) SAFETY NET PROVIDER PAYMENT AD-
18 JUSTMENTS IN NON-EXPANSION STATES.—Pay-
19 ment adjustments under subsection (a) of sec-
20 tion 1923A for which payment is permitted
21 under subsection (c) of such section.

22 “(D) EXPENDITURES FOR PUBLIC HEALTH
23 EMERGENCIES.—Any expenditures that are sub-
24 ject to a public health emergency exclusion
25 under paragraph (6).

1 “(4) 1903A BASE PERIOD POPULATION PER-
2 CENTAGE.—In this subsection, the term ‘1903A base
3 period population percentage’ means, for a State,
4 the Secretary’s calculation of the percentage of the
5 actual medical assistance expenditures, as reported
6 by the State on the CMS–64 reports for calendar
7 quarters in the State’s per capita base period, that
8 are attributable to 1903A enrollees (as defined in
9 subsection (e)(1)).

10 “(5) ADJUSTMENTS FOR PER CAPITA BASE PE-
11 RIOD.—In calculating medical assistance expendi-
12 tures under paragraph (2) and excluded expendi-
13 tures under paragraph (3) for a State for the State’s
14 per capita base period, the total amount of each type
15 of expenditure for the State and base period shall be
16 divided by 2.

17 “(6) AUTHORITY TO EXCLUDE STATE EXPENDI-
18 TURES FROM CAPS DURING PUBLIC HEALTH EMER-
19 GENCY.—

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

1 not exceed the amount determined under sub-
2 paragraph (B) for the State and year or portion
3 of a year if—

4 “(i) a public health emergency de-
5 clared by the Secretary pursuant to section
6 319 of the Public Health Service Act ex-
7 isted within the State during such year or
8 portion of a year; and

9 “(ii) the Secretary determines that
10 such an exemption would be appropriate.

11 “(B) MAXIMUM AMOUNT OF ADJUST-
12 MENT.—The amount excluded for a State and
13 fiscal year or portion of a fiscal year under this
14 paragraph shall not exceed the amount by
15 which—

16 “(i) the amount of State expenditures
17 for medical assistance for 1903A enrollees
18 in areas of the State which are subject to
19 a declaration described in subparagraph
20 (A)(i) for the fiscal year or portion of a fis-
21 cal year; exceeds

22 “(ii) the amount of such expenditures
23 for such enrollees in such areas during the
24 most recent fiscal year or portion of a fis-
25 cal year of equal length to the portion of

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

3 “(C) AGGREGATE LIMITATION ON EXCLU-
4 SIONS AND ADDITIONAL BLOCK GRANT PAY-
5 MENTS.—The aggregate amount of expendi-
6 tures excluded under this paragraph and addi-
7 tional payments made under section
8 1903B(c)(3)(E) for the period described in sub-
9 paragraph (A) shall not exceed \$5,000,000,000.

10 “(D) REVIEW.—If the Secretary exercises
11 the authority under this paragraph with respect
12 to a State for a fiscal year or portion of a fiscal
13 year, the Secretary shall, not later than 6
14 months after the declaration described in sub-
15 paragraph (A)(i) ceases to be in effect, conduct
16 an audit of the State’s medical assistance ex-
17 penditures for 1903A enrollees during the year
18 or portion of a year to ensure that all of the ex-
19 penditures so excluded were made for the pur-
20 pose of ensuring that the health care needs of
21 1903A enrollees in areas affected by a public
22 health emergency are met.

23 “(c) TARGET TOTAL MEDICAL ASSISTANCE EXPEND-
24 ITURES.—

1 “(1) CALCULATION.—In this section, the term
2 ‘target total medical assistance expenditures’ means,
3 for a State for a fiscal year and subject to para-
4 graph (4), the sum of the products, for each of the
5 1903A enrollee categories (as defined in subsection
6 (e)(2)), of—

7 “(A) the target per capita medical assist-
8 ance expenditures (as defined in paragraph (2))
9 for the enrollee category, State, and fiscal year;
10 and

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

14 “(2) TARGET PER CAPITA MEDICAL ASSISTANCE
15 EXPENDITURES.—In this subsection, the term ‘tar-
16 get per capita medical assistance expenditures’
17 means, for a 1903A enrollee category and State—

18 “(A) for fiscal year 2020, an amount equal
19 to—

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

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

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

6 “(i) the target per capita medical as-
7 sistance expenditures (under subparagraph
8 (A) or this subparagraph) for the 1903A
9 enrollee category and State for the pre-
10 ceding fiscal year; increased by

11 “(ii) the applicable annual inflation
12 factor for that succeeding fiscal year.

13 “(3) APPLICABLE ANNUAL INFLATION FAC-
14 TOR.—In paragraph (2), the term ‘applicable annual
15 inflation factor’ means—

16 “(A) for fiscal years before 2025—

17 “(i) for each of the 1903A enrollee
18 categories described in subparagraphs (C),
19 (D), and (E) of subsection (e)(2), the per-
20 centage increase in the medical care com-
21 ponent of the consumer price index for all
22 urban consumers (U.S. city average) from
23 September of the previous fiscal year to
24 September of the fiscal year involved; and

1 “(ii) for each of the 1903A enrollee
2 categories described in subparagraphs (A)
3 and (B) of subsection (e)(2), the percent-
4 age increase described in clause (i) plus 1
5 percentage point; and

6 “(B) for fiscal years after 2024, for all
7 1903A enrollee categories, the percentage in-
8 crease in the consumer price index for all urban
9 consumers (U.S. city average) from September
10 of the previous fiscal year to September of the
11 fiscal year involved.

12 “(4) DECREASE IN TARGET EXPENDITURES
13 FOR REQUIRED EXPENDITURES BY CERTAIN POLIT-
14 ICAL SUBDIVISIONS.—

15 “(A) IN GENERAL.—In the case of a State
16 that had a DSH allotment under section
17 1923(f) for fiscal year 2016 that was more than
18 6 times the national average of such allotments
19 for all the States for such fiscal year and that
20 requires political subdivisions within the State
21 to contribute funds towards medical assistance
22 or other expenditures under the State plan
23 under this title (or under a waiver of such plan)
24 for a fiscal year (beginning with fiscal year
25 2020), the target total medical assistance ex-

1 penditures for such State and fiscal year shall
2 be decreased by the amount that political sub-
3 divisions in the State are required to contribute
4 under the plan (or waiver) without reimburse-
5 ment from the State for such fiscal year, other
6 than contributions described in subparagraph
7 (B).

8 “(B) EXCEPTIONS.—The contributions de-
9 scribed in this subparagraph are the following:

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

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

17 “(II) imposes a local income tax
18 upon its residents.

19 “(ii) Contributions required by a
20 State from a political subdivision for ad-
21 ministrative expenses if the State required
22 such contributions from such subdivision
23 without reimbursement from the State as
24 of January 1, 2017.

1 “(5) ADJUSTMENTS TO STATE EXPENDITURES
2 TARGETS TO PROMOTE PROGRAM EQUITY ACROSS
3 STATES.—

4 “(A) IN GENERAL.—Beginning with fiscal
5 year 2020, the target per capita medical assist-
6 ance expenditures for a 1903A enrollee cat-
7 egory, State, and fiscal year, as determined
8 under paragraph (2), shall be adjusted (subject
9 to subparagraph (C)(i)) in accordance with this
10 paragraph.

11 “(B) ADJUSTMENT BASED ON LEVEL OF
12 PER CAPITA SPENDING FOR 1903A ENROLLEE
13 CATEGORIES.—Subject to subparagraph (C),
14 with respect to a State, fiscal year, and 1903A
15 enrollee category, if the State’s per capita cat-
16 egorical medical assistance expenditures (as de-
17 fined in subparagraph (D)) for the State and
18 category in the preceding fiscal year—

19 “(i) exceed the mean per capita cat-
20 egorical medical assistance expenditures
21 for the category for all States for such pre-
22 ceding year by not less than 25 percent,
23 the State’s target per capita medical as-
24 sistance expenditures for such category for
25 the fiscal year involved shall be reduced by

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

5 “(ii) are less than the mean per capita
6 categorical medical assistance expenditures
7 for the category for all States for such pre-
8 ceding year by not less than 25 percent,
9 the State’s target per capita medical as-
10 sistance expenditures for such category for
11 the fiscal year involved shall be increased
12 by a percentage that shall be determined
13 by the Secretary but which shall not be
14 less than 0.5 percent or greater than 3
15 percent.

16 “(C) RULES OF APPLICATION.—

17 “(i) BUDGET NEUTRALITY REQUIRE-
18 MENT.—In determining the appropriate
19 percentages by which to adjust States’ tar-
20 get per capita medical assistance expendi-
21 tures for a category and fiscal year under
22 this paragraph, the Secretary shall make
23 such adjustments in a manner that does
24 not result in a net increase in Federal pay-
25 ments under this section for such fiscal

1 year, and if the Secretary cannot adjust
2 such expenditures in such a manner there
3 shall be no adjustment under this para-
4 graph for such fiscal year.

5 “(ii) ASSUMPTION REGARDING STATE
6 EXPENDITURES.—For purposes of clause
7 (i), in the case of a State that has its tar-
8 get per capita medical assistance expendi-
9 tures for a 1903A enrollee category and
10 fiscal year increased under this paragraph,
11 the Secretary shall assume that the cat-
12 egorical medical assistance expenditures
13 (as defined in subparagraph (D)(ii)) for
14 such State, category, and fiscal year will
15 equal such increased target medical assist-
16 ance expenditures.

17 “(iii) NONAPPLICATION TO LOW-DEN-
18 SITY STATES.—This paragraph shall not
19 apply to any State that has a population
20 density of less than 15 individuals per
21 square mile, based on the most recent data
22 available from the Bureau of the Census.

23 “(iv) DISREGARD OF ADJUSTMENT.—
24 Any adjustment under this paragraph to
25 target medical assistance expenditures for

1 a State, 1903A enrollee category, and fis-
2 cal year shall be disregarded when deter-
3 mining the target medical assistance ex-
4 penditures for such State and category for
5 a succeeding year under paragraph (2).

6 “(v) APPLICATION FOR FISCAL YEARS
7 2020 AND 2021.—In fiscal years 2020 and
8 2021, the Secretary shall apply this para-
9 graph by deeming all categories of 1903A
10 enrollees to be a single category.

11 “(D) PER CAPITA CATEGORICAL MEDICAL
12 ASSISTANCE EXPENDITURES.—

13 “(i) IN GENERAL.—In this paragraph,
14 the term ‘per capita categorical medical as-
15 sistance expenditures’ means, with respect
16 to a State, 1903A enrollee category, and
17 fiscal year, an amount equal to—

18 “(I) the categorical medical ex-
19 penditures (as defined in clause (ii))
20 for the State, category, and year; di-
21 vided by

22 “(II) the number of 1903A en-
23 rollees for the State, category, and
24 year.

1 “(ii) CATEGORICAL MEDICAL ASSIST-
2 ANCE EXPENDITURES.—The term ‘categor-
3 ical medical assistance expenditures’
4 means, with respect to a State, 1903A en-
5 rollee category, and fiscal year, an amount
6 equal to the total medical assistance ex-
7 penditures (as defined in paragraph (2))
8 for the State and fiscal year that are at-
9 tributable to 1903A enrollees in the cat-
10 egory, excluding any excluded expenditures
11 (as defined in paragraph (3)) for the State
12 and fiscal year that are attributable to
13 1903A enrollees in the category.

14 “(d) CALCULATION OF FY19 PROVISIONAL TARGET
15 AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—Sub-
16 ject to subsection (g), the following shall apply:

17 “(1) CALCULATION OF BASE AMOUNTS FOR PER
18 CAPITA BASE PERIOD.—For each State the Sec-
19 retary shall calculate (and provide notice to the
20 State not later than April 1, 2018, of) the following:

21 “(A) The amount of the adjusted total
22 medical assistance expenditures (as defined in
23 subsection (b)(1)) for the State for the State’s
24 per capita base period.

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

4 “(C) The average per capita medical as-
5 sistance expenditures for the State for the
6 State’s per capita base period equal to—

7 “(i) the amount calculated under sub-
8 paragraph (A); divided by

9 “(ii) the number calculated under sub-
10 paragraph (B).

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

17 “(A) the average per capita medical assist-
18 ance expenditures for the State for the State’s
19 per capita base period (calculated under para-
20 graph (1)(C)); increased by

21 “(B) the percentage increase in the med-
22 ical care component of the consumer price index
23 for all urban consumers (U.S. city average)
24 from the last month of the State’s per capita
25 base period to September of fiscal year 2019.

1 “(3) AGGREGATE AND AVERAGE EXPENDI-
2 TURES PER CAPITA FOR FISCAL YEAR 2019.—The
3 Secretary shall calculate for each State the fol-
4 lowing:

5 “(A) The amount of the adjusted total
6 medical assistance expenditures (as defined in
7 subsection (b)(1)) for the State for fiscal year
8 2019.

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

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

17 “(A)(i) For each 1903A enrollee category,
18 the amount of the adjusted total medical assist-
19 ance expenditures (as defined in subsection
20 (b)(1)) for the State for fiscal year 2019 for in-
21 dividuals in the enrollee category, calculated by
22 excluding from medical assistance expenditures
23 those expenditures attributable to expenditures
24 described in clause (iii) or non-DSH supple-
25 mental expenditures (as defined in clause (ii)).

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

5 “(I) is not made under section 1923;

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

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

11 “(IV) complies with the limits for ad-
12 ditional payments to providers under the
13 plan (or waiver) imposed pursuant to sec-
14 tion 1902(a)(30)(A), including the regula-
15 tions specifying upper payment limits
16 under the State plan in part 447 of title
17 42, Code of Federal Regulations (or any
18 successor regulations).

19 “(iii) An expenditure described in this
20 clause is an expenditure that meets the criteria
21 specified in subclauses (I), (II), and (III) of
22 clause (ii) and is authorized under section 1115
23 for the purposes of funding a delivery system
24 reform pool, uncompensated care pool, a des-
25 ignated State health program, or any other

1 similar expenditure (as defined by the Sec-
2 retary).

3 “(B) For each 1903A enrollee category,
4 the number of 1903A enrollees for the State in
5 fiscal year 2019 in the enrollee category (as de-
6 termined under subsection (e)(4)).

7 “(C) For the State’s per capita base pe-
8 riod, the State’s non-DSH supplemental and
9 pool payment percentage is equal to the ratio
10 (expressed as a percentage) of—

11 “(i) the total amount of non-DSH
12 supplemental expenditures (as defined in
13 subparagraph (A)(ii) and adjusted under
14 subparagraph (E)) and payments described
15 in subparagraph (A)(iii) (and adjusted
16 under subparagraph (E)) for the State for
17 the period; to

18 “(ii) the amount described in sub-
19 section (b)(1)(A) for the State for the
20 State’s per capita base period.

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

1 “(i) the amount calculated under sub-
2 paragraph (A) for the State, increased by
3 the non-DSH supplemental and pool pay-
4 ment percentage for the State (as cal-
5 culated under subparagraph (C)); divided
6 by

7 “(ii) the number calculated under sub-
8 paragraph (B) for the State for the en-
9 rollee category.

10 “(E) For purposes of subparagraph (C)(i),
11 in calculating the total amount of non-DSH
12 supplemental expenditures and payments de-
13 scribed in subparagraph (A)(iii) for a State for
14 the per capita base period, the total amount of
15 such expenditures and the total amount of such
16 payments for the State and base period shall
17 each be divided by 2.

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

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

3 “(A) the product of—

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

7 “(ii) the number of 1903A enrollees
8 for the State in fiscal year 2019, as cal-
9 culated under paragraph (3)(B); to

10 “(B) the amount of the adjusted total
11 medical assistance expenditures for the State
12 for fiscal year 2019, as calculated under para-
13 graph (3)(A).

14 “(e) 1903A ENROLLEE; 1903A ENROLLEE CAT-
15 EGORY.—Subject to subsection (g), for purposes of this
16 section, the following shall apply:

17 “(1) 1903A ENROLLEE.—The term ‘1903A en-
18 rollee’ means, with respect to a State and a month
19 and subject to subsection (i)(1)(B), any Medicaid
20 enrollee (as defined in paragraph (3)) for the month,
21 other than such an enrollee who for such month is
22 in any of the following categories of excluded indi-
23 viduals:

24 “(A) CHIP.—An individual who is pro-
25 vided, under this title in the manner described

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

3 “(B) IHS.—An individual who receives
4 any medical assistance under this title for serv-
5 ices for which payment is made under the third
6 sentence of section 1905(b).

7 “(C) BREAST AND CERVICAL CANCER
8 SERVICES ELIGIBLE INDIVIDUAL.—An indi-
9 vidual who is eligible for medical assistance
10 under this title only on the basis of section
11 1902(a)(10)(A)(ii)(XVIII).

12 “(D) PARTIAL-BENEFIT ENROLLEES.—An
13 individual who—

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

17 “(ii) is eligible for medical assistance
18 under this title only on the basis of sub-
19 clause (XII) or (XXI) of section
20 1902(a)(10)(A)(ii) (or on the basis of a
21 waiver that provides only comparable bene-
22 fits);

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

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

4 “(iv) is eligible for medical assistance
5 under this title and for whom the State is
6 providing a payment or subsidy to an em-
7 ployer for coverage of the individual under
8 a group health plan pursuant to section
9 1906 or section 1906A (or pursuant to a
10 waiver that provides only comparable bene-
11 fits).

12 “(E) BLIND AND DISABLED CHILDREN.—

13 An individual who—

14 “(i) is a child under 19 years of age;
15 and

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

19 “(2) 1903A ENROLLEE CATEGORY.—The term
20 ‘1903A enrollee category’ means each of the fol-
21 lowing:

22 “(A) ELDERLY.—A category of 1903A en-
23 rollees who are 65 years of age or older.

1 “(B) BLIND AND DISABLED.—A category
2 of 1903A enrollees (not described in the pre-
3 vious subparagraph) who—

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

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

8 “(C) CHILDREN.—A category of 1903A
9 enrollees (not described in a previous subpara-
10 graph) who are children under 19 years of age.

11 “(D) EXPANSION ENROLLEES.—A cat-
12 egory of 1903A enrollees (not described in a
13 previous subparagraph) who are eligible for
14 medical assistance under this title only on the
15 basis of clause (i)(VIII), (ii)(XX), or
16 (ii)(XXIII) of section 1902(a)(10)(A).

17 “(E) OTHER NONELDERLY, NONDISABLED,
18 NON-EXPANSION ADULTS.—A category of
19 1903A enrollees who are not described in any
20 previous subparagraph.

21 “(3) MEDICAID ENROLLEE.—The term ‘Med-
22 icaid enrollee’ means, with respect to a State for a
23 month, an individual who is eligible for medical as-
24 sistance for items or services under this title and en-

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

3 “(4) DETERMINATION OF NUMBER OF 1903A
4 ENROLLEES.—The number of 1903A enrollees for a
5 State and fiscal year or the State’s per capita base
6 period, and, if applicable, for a 1903A enrollee cat-
7 egory, is the average monthly number of Medicaid
8 enrollees for such State and fiscal year or base pe-
9 riod (and, if applicable, in such category) that are
10 reported through the CMS–64 report under (and
11 subject to audit under) subsection (h).

12 “(f) SPECIAL PAYMENT RULES.—

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

1 ita limitation) otherwise applicable under such a
2 waiver.

3 “(2) TREATMENT OF STATES EXPANDING COV-
4 ERAGE AFTER JULY 1, 2016.—In the case of a State
5 that did not provide for medical assistance for the
6 1903A enrollee category described in subsection
7 (e)(2)(D) as of July 1, 2016, but which subsequently
8 provides for such assistance for such category, the
9 provisional FY19 per capita target amount for such
10 enrollee category under subsection (d)(5) shall be
11 equal to the provisional FY19 per capita target
12 amount for the 1903A enrollee category described in
13 subsection (e)(2)(E).

14 “(3) IN CASE OF STATE FAILURE TO REPORT
15 NECESSARY DATA.—If a State for any quarter in a
16 fiscal year (beginning with fiscal year 2019) fails to
17 satisfactorily submit data on expenditures and en-
18 rollees in accordance with subsection (h)(1), for such
19 fiscal year and any succeeding fiscal year for which
20 such data are not satisfactorily submitted—

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

1 were not satisfactorily submitted were a single
2 1903A enrollee category; and

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

6 “(g) RECALCULATION OF CERTAIN AMOUNTS FOR
7 DATA ERRORS.—The amounts and percentage calculated
8 under paragraphs (1) and (4)(C) of subsection (d) for a
9 State for the State’s per capita base period, and the
10 amounts of the adjusted total medical assistance expendi-
11 tures calculated under subsection (b) and the number of
12 Medicaid enrollees and 1903A enrollees determined under
13 subsection (e)(4) for a State for the State’s per capita
14 base period, fiscal year 2019, and any subsequent fiscal
15 year, may be adjusted by the Secretary based upon an ap-
16 peal (filed by the State in such a form, manner, and time,
17 and containing such information relating to data errors
18 that support such appeal, as the Secretary specifies) that
19 the Secretary determines to be valid, except that any ad-
20 justment by the Secretary under this subsection for a
21 State may not result in an increase of the target total
22 medical assistance expenditures exceeding 2 percent.

23 “(h) REQUIRED REPORTING AND AUDITING; TRANSI-
24 TIONAL INCREASE IN FEDERAL MATCHING PERCENTAGE
25 FOR CERTAIN ADMINISTRATIVE EXPENSES.—

1 “(1) REPORTING OF CMS-64 DATA.—

2 “(A) IN GENERAL.—In addition to the
3 data required on form Group VIII on the CMS-
4 64 report form as of January 1, 2017, in each
5 CMS-64 report required to be submitted (for
6 each quarter beginning on or after October 1,
7 2018), the State shall include data on medical
8 assistance expenditures within such categories
9 of services and categories of enrollees (including
10 each 1903A enrollee category and each category
11 of excluded individuals under subsection (e)(1))
12 and the numbers of enrollees within each of
13 such enrollee categories, as the Secretary deter-
14 mines are necessary (including timely guidance
15 published as soon as possible after the date of
16 the enactment of this section) in order to imple-
17 ment this section and to enable States to com-
18 ply with the requirement of this paragraph on
19 a timely basis.

20 “(B) REPORTING ON QUALIFIED INPA-
21 TIENT PSYCHIATRIC HOSPITAL SERVICES.—Not
22 later than 60 days after the date of the enact-
23 ment of this section, the Secretary shall modify
24 the CMS-64 report form to require that States
25 submit data with respect to medical assistance

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

4 “(C) REPORTING ON CHILDREN WITH
5 COMPLEX MEDICAL CONDITIONS.—Not later
6 than January 1, 2020, the Secretary shall mod-
7 ify the CMS–64 report form to require that
8 States submit data with respect to individuals
9 who—

10 “(i) are enrolled in a State plan under
11 this title or title XXI or under a waiver of
12 such plan;

13 “(ii) are under 21 years of age; and

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

16 “(I) affects two or more body
17 systems;

18 “(II) affects cognitive or physical
19 functioning (such as reducing the abil-
20 ity to perform the activities of daily
21 living, including the ability to engage
22 in movement or mobility, eat, drink,
23 communicate, or breathe independ-
24 ently); and

25 “(III) either—

1 “(aa) requires intensive
2 healthcare interventions (such as
3 multiple medications, therapies,
4 or durable medical equipment)
5 and intensive care coordination to
6 optimize health and avoid hos-
7 pitalizations or emergency de-
8 partment visits; or

9 “(bb) meets the criteria for
10 medical complexity under existing
11 risk adjustment methodologies
12 using a recognized, publicly avail-
13 able pediatric grouping system
14 (such as the pediatric complex
15 conditions classification system
16 or the Pediatric Medical Com-
17 plexity Algorithm) selected by the
18 Secretary in close collaboration
19 with the State agencies respon-
20 sible for administering State
21 plans under this title and a na-
22 tional panel of pediatric, pedi-
23 atric specialty, and pediatric sub-
24 specialty experts.

1 “(2) AUDITING OF CMS-64 DATA.—The Sec-
2 retary shall conduct for each State an audit of the
3 number of individuals and expenditures reported
4 through the CMS-64 report for the State’s per cap-
5 ita base period, fiscal year 2019, and each subse-
6 quent fiscal year, which audit may be conducted on
7 a representative sample (as determined by the Sec-
8 retary).

9 “(3) AUDITING OF STATE SPENDING.—The In-
10 spector General of the Department of Health and
11 Human Services shall conduct an audit (which shall
12 be conducted using random sampling, as determined
13 by the Inspector General) of each State’s spending
14 under this section not less than once every 3 years.

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

1 “(A) the Federal matching percentage ap-
2 plied under section 1903(a)(3)(A)(i) shall be in-
3 creased by 10 percentage points to 100 percent;

4 “(B) the Federal matching percentage ap-
5 plied under section 1903(a)(3)(B) shall be in-
6 creased by 25 percentage points to 100 percent;

7 and

8 “(C) the Federal matching percentage ap-
9 plied under section 1903(a)(7) shall be in-
10 creased by 10 percentage points to 60 percent
11 but only with respect to amounts expended that
12 are attributable to a State’s additional adminis-
13 trative expenditures to implement the data re-
14 quirements of paragraph (1).

15 “(5) HHS REPORT ON ADOPTION OF T-MSIS
16 DATA.—Not later than January 1, 2025, the Sec-
17 retary shall submit to Congress a report making rec-
18 ommendations as to whether data from the Trans-
19 formed Medicaid Statistical Information System
20 would be preferable to CMS-64 report data for pur-
21 poses of making the determinations necessary under
22 this section.”.

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

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

3 “(l) INCENTIVE PAYMENTS FOR HOME AND COMMU-
4 NITY-BASED SERVICES.—

5 “(1) IN GENERAL.—The Secretary shall estab-
6 lish a demonstration project (referred to in this sub-
7 section as the ‘demonstration project’) under which
8 eligible States may make HCBS payment adjust-
9 ments for the purpose of continuing to provide and
10 improving the quality of home and community-based
11 services provided under a waiver under subsection
12 (c) or (d) or a State plan amendment under sub-
13 section (i).

14 “(2) SELECTION OF ELIGIBLE STATES.—

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

20 “(i) an assurance that any HCBS
21 payment adjustment made by the State
22 under this subsection will comply with the
23 health and welfare and financial account-
24 ability safeguards taken by the State under
25 subsection (c)(2)(A); and

1 may be allotted to eligible States under
2 clause (i) for all years of the demonstra-
3 tion project shall not exceed
4 \$8,000,000,000, and in no case may the
5 aggregate amount of payments made by
6 the Secretary to eligible States for pay-
7 ment adjustments under this subsection
8 exceed such amount.

9 “(B) PAYMENTS TO ELIGIBLE STATES AND
10 LIMITATIONS ON PAYMENTS.—

11 “(i) IN GENERAL.—Subject to clauses
12 (ii) and (iii), for each year of the dem-
13 onstration project, notwithstanding section
14 1905(b), the Federal medical assistance
15 percentage applicable with respect to ex-
16 penditures by an eligible State that are at-
17 tributable to HCBS payment adjustments
18 shall be equal to (and shall in no case ex-
19 ceed) 100 percent.

20 “(ii) LIMITATION ON HCBS PAYMENT
21 ADJUSTMENTS FOR INDIVIDUAL PRO-
22 VIDERS.—Payment under section 1903(a)
23 shall not be made to an eligible State for
24 expenditures for a year that are attrib-
25 utable to an HCBS payment adjustment

1 that is paid to a single provider and ex-
2 ceeds a percentage which shall be estab-
3 lished by the Secretary of the payment oth-
4 erwise made to the provider.

5 “(iii) LIMITATION OF PAYMENT TO
6 AMOUNT OF ALLOTMENT.—Payment under
7 section 1903(a) shall not be made to an el-
8 igible State for expenditures for a year
9 that are attributable to an HCBS payment
10 adjustment to the extent that the aggre-
11 gate amount of HCBS payment adjust-
12 ments made by the State in the year ex-
13 ceeds the amount allotted to the State for
14 the year under subparagraph (A)(i).

15 “(5) REPORTING AND EVALUATION.—

16 “(A) IN GENERAL.—As a condition of re-
17 ceiving the increased Federal medical assistance
18 percentage described in paragraph (4)(B)(i),
19 each eligible State shall collect and report infor-
20 mation, as determined necessary by the Sec-
21 retary, for the purposes of providing Federal
22 oversight and evaluating the State’s compliance
23 with the health and welfare and financial ac-
24 countability safeguards taken by the State
25 under subsection (c)(2)(A).

1 “(B) FORMS.—Expenditures by eligible
2 States on HCBS payment adjustments shall be
3 separately reported on the CMS-64 Form and
4 in T-MSIS.

5 “(6) DEFINITIONS.—In this subsection:

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

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

10 “(ii) has in effect—

11 “(I) a waiver under subsection
12 (c) or (d); or

13 “(II) a State plan amendment
14 under subsection (i);

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

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

19 “(B) HCBS PAYMENT ADJUSTMENT.—The
20 term ‘HCBS payment adjustment’ means a
21 payment adjustment made by an eligible State
22 to the amount of payment otherwise provided
23 under a waiver under subsection (c) or (d) or
24 a State plan amendment under subsection (i)
25 for a home and community-based service which

1 is provided to a 1903A enrollee (as defined in
2 section 1903A(e)(1)) who is in the enrollee cat-
3 egory described in subparagraph (A) or (B) of
4 section 1903A(e)(2).”.

5 **SEC. 133. FLEXIBLE BLOCK GRANT OPTION FOR STATES.**

6 Title XIX of the Social Security Act, as amended by
7 section 132, is further amended by inserting after section
8 1903A the following new section:

9 **“SEC. 1903B. MEDICAID FLEXIBILITY PROGRAM.**

10 “(a) IN GENERAL.—Beginning with fiscal year 2020,
11 any State (as defined in subsection (e)) that has an appli-
12 cation approved by the Secretary under subsection (b)
13 may conduct a Medicaid Flexibility Program to provide
14 targeted health assistance to program enrollees.

15 “(b) STATE APPLICATION.—

16 “(1) IN GENERAL.—To be eligible to conduct a
17 Medicaid Flexibility Program, a State shall submit
18 an application to the Secretary that meets the re-
19 quirements of this subsection.

20 “(2) CONTENTS OF APPLICATION.—An applica-
21 tion under this subsection shall include the fol-
22 lowing:

23 “(A) A description of the proposed Med-
24 icaid Flexibility Program and how the State will

1 satisfy the requirements described in subsection
2 (d).

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

5 “(C) The applicable program enrollee cat-
6 egory (as defined in subsection (e)(1)).

7 “(D) A description of the types, amount,
8 duration, and scope of services which will be of-
9 fered as targeted health assistance under the
10 program, including a description of the pro-
11 posed package of services which will be provided
12 to program enrollees to whom the State would
13 otherwise be required to make medical assist-
14 ance available under section 1902(a)(10)(A)(i).

15 “(E) A description of how the State will
16 notify individuals currently enrolled in the State
17 plan for medical assistance under this title of
18 the transition to such program.

19 “(F) Statements certifying that the State
20 agrees to—

21 “(i) submit regular enrollment data
22 with respect to the program to the Centers
23 for Medicare & Medicaid Services at such
24 time and in such manner as the Secretary
25 may require;

1 “(ii) submit timely and accurate data
2 to the Transformed Medicaid Statistical
3 Information System (T-MSIS);

4 “(iii) report annually to the Secretary
5 on adult health quality measures imple-
6 mented under the program and informa-
7 tion on the quality of health care furnished
8 to program enrollees under the program as
9 part of the annual report required under
10 section 1139B(d)(1);

11 “(iv) submit such additional data and
12 information not described in any of the
13 preceding clauses of this subparagraph but
14 which the Secretary determines is nec-
15 essary for monitoring, evaluation, or pro-
16 gram integrity purposes, including—

17 “(I) survey data, such as the
18 data from Consumer Assessment of
19 Healthcare Providers and Systems
20 (CAHPS) surveys;

21 “(II) birth certificate data; and

22 “(III) clinical patient data for
23 quality measurements which may not
24 be present in a claim, such as labora-

1 tory data, body mass index, and blood
2 pressure; and

3 “(v) on an annual basis, conduct a re-
4 port evaluating the program and make
5 such report available to the public.

6 “(G) An information technology systems
7 plan demonstrating that the State has the capa-
8 bility to support the technological administra-
9 tion of the program and comply with reporting
10 requirements under this section.

11 “(H) A statement of the goals of the pro-
12 posed program, which shall include—

13 “(i) goals related to quality, access,
14 rate of growth targets, consumer satisfac-
15 tion, and outcomes;

16 “(ii) a plan for monitoring and evalu-
17 ating the program to determine whether
18 such goals are being met; and

19 “(iii) a proposed process for the State,
20 in consultation with the Centers for Medi-
21 care & Medicaid Services, to take remedial
22 action to make progress on unmet goals.

23 “(I) Such other information as the Sec-
24 retary may require.

25 “(3) STATE NOTICE AND COMMENT PERIOD.—

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

5 “(B) NOTICE AND COMMENT PROCESS.—
6 During the notice and comment period de-
7 scribed in subparagraph (A), the State shall
8 provide opportunities for a meaningful level of
9 public input, which shall include public hearings
10 on the proposed Medicaid Flexibility Program.

11 “(4) FEDERAL NOTICE AND COMMENT PE-
12 RIOD.—The Secretary shall not approve of any ap-
13 plication to conduct a Medicaid Flexibility Program
14 without making such application publicly available
15 for a 30 day notice and comment period.

16 “(5) TIMELINE FOR SUBMISSION.—

17 “(A) IN GENERAL.—A State may submit
18 an application under this subsection to conduct
19 a Medicaid Flexibility Program that would
20 begin in the next fiscal year at any time, sub-
21 ject to subparagraph (B).

22 “(B) DEADLINES.—Each year beginning
23 with 2019, the Secretary shall specify a dead-
24 line for submitting an application under this
25 subsection to conduct a Medicaid Flexibility

1 Program that would begin in the next fiscal
2 year, but such deadline shall not be earlier than
3 60 days after the date that the Secretary pub-
4 lishes the amounts of State block grants as re-
5 quired under subsection (c)(4).

6 “(c) FINANCING.—

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

13 “(2) AMOUNT OF BLOCK GRANT FUNDS.—

14 “(A) IN GENERAL.—The block grant
15 amount under this paragraph for a State and
16 year shall be equal to the sum of the amounts
17 determined under subparagraph (B) for each
18 1903A enrollee category within the applicable
19 program enrollee category for the State and
20 year.

21 “(B) ENROLLEE CATEGORY AMOUNTS.—

22 “(i) FOR INITIAL YEAR.—Subject to
23 subparagraph (C), for the first fiscal year
24 in which a 1903A enrollee category is in-
25 cluded in the applicable program enrollee

1 category for a Medicaid Flexibility Pro-
2 gram conducted by the State, the amount
3 determined under this subparagraph for
4 the State, year, and category shall be equal
5 to the Federal average medical assistance
6 matching percentage (as defined in section
7 1903A(a)(4)) for the State and year multi-
8 plied by the product of—

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

13 “(II) the number of 1903A en-
14 rollees in such category for the State
15 for the second fiscal year preceding
16 such first fiscal year, increased by the
17 percentage increase in State popu-
18 lation from such second preceding fis-
19 cal year to such first fiscal year, based
20 on the best available estimates of the
21 Bureau of the Census.

22 “(ii) FOR ANY SUBSEQUENT YEAR.—
23 For any fiscal year that is not the first fis-
24 cal year in which a 1903A enrollee cat-
25 egory is included in the applicable program

1 enrollee category for a Medicaid Flexibility
2 Program conducted by the State, the block
3 grant amount under this paragraph for the
4 State, year, and category shall be equal to
5 the amount determined for the State and
6 category for the most recent previous fiscal
7 year in which the State conducted a Med-
8 icaid Flexibility Program that included
9 such category, except that such amount
10 shall be increased by the percentage in-
11 crease in the consumer price index for all
12 urban consumers (U.S. city average) from
13 April of the second fiscal year preceding
14 the fiscal year involved to April of the fis-
15 cal year preceding the fiscal year involved.

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

19 “(i) IN GENERAL.—In calculating the
20 amount of a block grant for the first year
21 in which a 1903A enrollee category is in-
22 cluded in the applicable program enrollee
23 category for a Medicaid Flexibility Pro-
24 gram conducted by the State under sub-
25 paragraph (B)(i), the total number of

1 1903A enrollees in such 1903A enrollee
2 category for the State and year shall not
3 exceed the adjusted number of base period
4 enrollees for the State (as defined in clause
5 (ii)).

6 “(ii) ADJUSTED NUMBER OF BASE PE-
7 RIOD ENROLLEES.—The term ‘adjusted
8 number of base period enrollees’ means,
9 with respect to a State and 1903A enrollee
10 category, the number of 1903A enrollees in
11 the enrollee category for the State for the
12 State’s per capita base period (as deter-
13 mined under section 1903A(e)(4)), in-
14 creased by the percentage increase, if any,
15 in the total State population from the last
16 April in the State’s per capita base period
17 to April of the fiscal year preceding the fis-
18 cal year involved (determined using the
19 best available data from the Bureau of the
20 Census) plus 3 percentage points.

21 “(D) AVAILABILITY OF ROLLOVER
22 FUNDS.—

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

1 graph exceeds the amount of Federal pay-
2 ments made to the State for such fiscal
3 year under paragraph (3)(A), the Sec-
4 retary shall make such funds available to
5 the State for the succeeding fiscal year if
6 the State—

7 “(I) satisfies the State mainte-
8 nance of effort requirement under
9 paragraph (3)(B); and

10 “(II) is conducting a Medicaid
11 Flexibility Program in such suc-
12 ceeding fiscal year.

13 “(ii) USE OF FUNDS.—Funds made
14 available to a State under this subpara-
15 graph shall only be used for expenditures
16 related to the State plan under this title or
17 to the State Medicaid Flexibility Program.

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

19
20 “(A) FEDERAL PAYMENT.—Subject to sub-
21 paragraphs (D) and (E), the Secretary shall
22 pay to each State conducting a Medicaid Flexi-
23 bility Program under this section for a fiscal
24 year, from its block grant amount under para-
25 graph (2) for such year, an amount for each

1 quarter of such year equal to the Federal aver-
2 age medical assistance percentage (as defined in
3 section 1903A(a)(4)) of the total amount ex-
4 pended under the program during such quarter
5 as targeted health assistance, and the State is
6 responsible for the balance of the funds to carry
7 out such program.

8 “(B) STATE MAINTENANCE OF EFFORT
9 EXPENDITURES.—For each year during which a
10 State is conducting a Medicaid Flexibility Pro-
11 gram, the State shall make expenditures for
12 targeted health assistance under the program in
13 an amount equal to the product of—

14 “(i) the block grant amount deter-
15 mined for the State and year under para-
16 graph (2); and

17 “(ii) the enhanced FMAP described in
18 the first sentence of section 2105(b) for
19 the State and year.

20 “(C) REDUCTION IN BLOCK GRANT
21 AMOUNT FOR STATES FAILING TO MEET MOE
22 REQUIREMENT.—

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

1 geted health assistance under the program
2 for a fiscal year in an amount that is less
3 than the required amount for the fiscal
4 year under subparagraph (B), the amount
5 of the block grant determined for the State
6 under paragraph (2) for the succeeding fis-
7 cal year shall be reduced by the amount by
8 which such expenditures are less than such
9 required amount.

10 “(ii) DISREGARD OF REDUCTION.—
11 For purposes of determining the amount of
12 a State block grant under paragraph (2),
13 any reduction made under this subpara-
14 graph to a State’s block grant amount in
15 a previous fiscal year shall be disregarded.

16 “(iii) APPLICATION TO STATES THAT
17 TERMINATE PROGRAM.—In the case of a
18 State described in clause (i) that termi-
19 nates the State Medicaid Flexibility Pro-
20 gram under subsection (d)(2)(B) and such
21 termination is effective with the end of the
22 fiscal year in which the State fails to make
23 the required amount of expenditures under
24 subparagraph (B), the reduction amount
25 determined for the State and succeeding

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

3 “(D) REDUCTION FOR NONCOMPLIANCE.—

4 If the Secretary determines that a State con-
5 ducting a Medicaid Flexibility Program is not
6 complying with the requirements of this section,
7 the Secretary may withhold payments, reduce
8 payments, or recover previous payments to the
9 State under this section as the Secretary deems
10 appropriate.

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

13 “(i) IN GENERAL.—In the case of a
14 State and fiscal year or portion of a fiscal
15 year for which the Secretary has excluded
16 expenditures under section 1903A(b)(6), if
17 the State has uncompensated targeted
18 health assistance expenditures for the year
19 or portion of a year, the Secretary may
20 make an additional payment to such State
21 equal to the Federal average medical as-
22 sistance percentage (as defined in section
23 1903A(a)(4)) for the year or portion of a
24 year of the amount of such uncompensated
25 targeted health assistance expenditures, ex-

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

5 “(ii) MAXIMUM AMOUNT OF ADDI-
6 TIONAL PAYMENT.—The amount deter-
7 mined for a State and fiscal year or por-
8 tion of a fiscal year under this subpara-
9 graph shall not exceed the Federal average
10 medical assistance percentage (as defined
11 in section 1903A(a)(4)) for such year or
12 portion of a year of the amount by
13 which—

14 “(I) the amount of State expend-
15 itures for targeted health assistance
16 for program enrollees in areas of the
17 State which are subject to a declara-
18 tion described in section
19 1903A(b)(6)(A)(i) for the year or por-
20 tion of a year; exceeds

21 “(II) the amount of such expend-
22 itures for such enrollees in such areas
23 during the most recent fiscal year in-
24 volved (or portion of a fiscal year of
25 equal length to the portion of a fiscal

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

3 “(iii) UNCOMPENSATED TARGETED
4 HEALTH ASSISTANCE.—In this subpara-
5 graph, the term ‘uncompensated targeted
6 health assistance expenditures’ means,
7 with respect to a State and fiscal year or
8 portion of a fiscal year, an amount equal
9 to the amount (if any) by which—

10 “(I) the total amount expended
11 by the State under the program for
12 targeted health assistance for the year
13 or portion of a year; exceeds

14 “(II) the amount equal to the
15 amount of the block grant (reduced,
16 in the case of a portion of a year, to
17 the same proportion of the full block
18 grant amount that the portion of the
19 year bears to the whole year) divided
20 by the Federal average medical assist-
21 ance percentage for the year or por-
22 tion of a year.

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

1 retary shall, not later than 6 months after
2 the declaration described in section
3 1903A(b)(6)(A)(i) ceases to be in effect,
4 conduct an audit of the State’s targeted
5 health assistance expenditures for program
6 enrollees during the year or portion of a
7 year to ensure that all of the expenditures
8 for which the additional payment was
9 made were made for the purpose of ensur-
10 ing that the health care needs of program
11 enrollees in areas affected by a public
12 health emergency are met.

13 “(4) DETERMINATION AND PUBLICATION OF
14 BLOCK GRANT AMOUNT.—Beginning in 2019 and
15 each year thereafter, the Secretary shall determine
16 for each State, regardless of whether the State is
17 conducting a Medicaid Flexibility Program or has
18 submitted an application to conduct such a program,
19 the amount of the block grant for the State under
20 paragraph (2) which would apply for the upcoming
21 fiscal year if the State were to conduct such a pro-
22 gram in such fiscal year, and shall publish such de-
23 terminations not later than June 1 of each year.

24 “(d) PROGRAM REQUIREMENTS.—

1 “(1) IN GENERAL.—No payment shall be made
2 under this section to a State conducting a Medicaid
3 Flexibility Program unless such program meets the
4 requirements of this subsection.

5 “(2) TERM OF PROGRAM.—

6 “(A) IN GENERAL.—A State Medicaid
7 Flexibility Program approved under subsection
8 (b)—

9 “(i) shall be conducted for not less
10 than 1 program period;

11 “(ii) at the option of the State, may
12 be continued for succeeding program peri-
13 ods without resubmitting an application
14 under subsection (b), provided that—

15 “(I) the State provides notice to
16 the Secretary of its decision to con-
17 tinue the program; and

18 “(II) no significant changes are
19 made to the program; and

20 “(iii) shall be subject to termination
21 only by the State, which may terminate the
22 program by making an election under sub-
23 paragraph (B).

24 “(B) ELECTION TO TERMINATE PRO-
25 GRAM.—

1 “(i) IN GENERAL.—Subject to clause
2 (ii), a State conducting a Medicaid Flexi-
3 bility Program may elect to terminate the
4 program effective with the first day after
5 the end of the program period in which the
6 State makes the election.

7 “(ii) TRANSITION PLAN REQUIRE-
8 MENT.—A State may not elect to termi-
9 nate a Medicaid Flexibility Program unless
10 the State has in place an appropriate tran-
11 sition plan approved by the Secretary.

12 “(iii) EFFECT OF TERMINATION.—If a
13 State elects to terminate a Medicaid Flexi-
14 bility Program, the per capita cap limita-
15 tions under section 1903A shall apply ef-
16 fective with the day described in clause (i),
17 and such limitations shall be applied as if
18 the State had never conducted a Medicaid
19 Flexibility Program.

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

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

1 which would otherwise be provided to the enroll-
2 ees under this title.

3 “(B) CONDITIONS FOR ELIGIBILITY.—

4 “(i) IN GENERAL.—A State con-
5 ducting a Medicaid Flexibility Program
6 shall establish conditions for eligibility of
7 program enrollees, which shall be instead
8 of other conditions for eligibility under this
9 title, except that the program must provide
10 for eligibility for program enrollees to
11 whom the State would otherwise be re-
12 quired to make medical assistance available
13 under section 1902(a)(10)(A)(i).

14 “(ii) MAGI.—Any determination of
15 income necessary to establish the eligibility
16 of a program enrollee for purposes of a
17 State Medicaid Flexibility Program shall
18 be made using modified adjusted gross in-
19 come in accordance with section
20 1902(e)(14).

21 “(4) BENEFITS AND SERVICES.—

22 “(A) REQUIRED SERVICES.—In the case of
23 program enrollees to whom the State would oth-
24 erwise be required to make medical assistance
25 available under section 1902(a)(10)(A)(i), a

1 State conducting a Medicaid Flexibility Pro-
2 gram shall provide as targeted health assistance
3 the following types of services:

4 “(i) Inpatient and outpatient hospital
5 services.

6 “(ii) Laboratory and X-ray services.

7 “(iii) Nursing facility services for indi-
8 viduals aged 21 and older.

9 “(iv) Physician services.

10 “(v) Home health care services (in-
11 cluding home nursing services, medical
12 supplies, equipment, and appliances).

13 “(vi) Rural health clinic services (as
14 defined in section 1905(1)(1)).

15 “(vii) Federally-qualified health center
16 services (as defined in section 1905(1)(2)).

17 “(viii) Family planning services and
18 supplies.

19 “(ix) Nurse midwife services.

20 “(x) Certified pediatric and family
21 nurse practitioner services.

22 “(xi) Freestanding birth center serv-
23 ices (as defined in section 1905(1)(3)).

24 “(xii) Emergency medical transpor-
25 tation.

1 “(xiii) Non-cosmetic dental services.

2 “(xiv) Pregnancy-related services, in-
3 cluding postpartum services for the 12-
4 week period beginning on the last day of a
5 pregnancy.

6 “(B) OPTIONAL BENEFITS.—A State may,
7 at its option, provide services in addition to the
8 services described in subparagraph (A) as tar-
9 geted health assistance under a Medicaid Flexi-
10 bility Program.

11 “(C) BENEFIT PACKAGES.—

12 “(i) IN GENERAL.—The targeted
13 health assistance provided by a State to
14 any group of program enrollees under a
15 Medicaid Flexibility Program shall have an
16 aggregate actuarial value that is equal to
17 at least 95 percent of the aggregate actu-
18 arial value of the benchmark coverage de-
19 scribed in subsection (b)(1) of section 1937
20 or benchmark-equivalent coverage de-
21 scribed in subsection (b)(2) of such sec-
22 tion, as such subsections were in effect
23 prior to the enactment of the Patient Pro-
24 tection and Affordable Care Act.

1 “(iv) PRESCRIPTION DRUGS.—If the
2 targeted health assistance provided by a
3 State to program enrollees under a Med-
4 icaid Flexibility Program includes assist-
5 ance for covered outpatient drugs, such
6 drugs shall be subject to a rebate agree-
7 ment that complies with the requirements
8 of section 1927, and any requirements ap-
9 plicable to medical assistance for covered
10 outpatient drugs under a State plan (in-
11 cluding the requirement that the State pro-
12 vide information to a manufacturer) shall
13 apply in the same manner to targeted
14 health assistance for covered outpatient
15 drugs under a Medicaid Flexibility Pro-
16 gram.

17 “(D) COST SHARING.—A State conducting
18 a Medicaid Flexibility Program may impose
19 premiums, deductibles, cost-sharing, or other
20 similar charges, except that the total annual ag-
21 gregate amount of all such charges imposed
22 with respect to all program enrollees in a family
23 shall not exceed 5 percent of the family’s in-
24 come for the year involved.

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

4 “(A) SINGLE AGENCY.—Designate a single
5 State agency responsible for administering the
6 program.

7 “(B) ENROLLMENT SIMPLIFICATION AND
8 COORDINATION WITH STATE HEALTH INSUR-
9 ANCE EXCHANGES.—Provide for simplified en-
10 rollment processes (such as online enrollment
11 and reenrollment and electronic verification)
12 and coordination with State health insurance
13 exchanges.

14 “(C) BENEFICIARY PROTECTIONS.—Estab-
15 lish a fair process (which the State shall de-
16 scribe in the application required under sub-
17 section (b)) for individuals to appeal adverse
18 eligibility determinations with respect to the
19 program.

20 “(6) APPLICATION OF REST OF TITLE XIX.—

21 “(A) IN GENERAL.—To the extent that a
22 provision of this section is inconsistent with an-
23 other provision of this title, the provision of this
24 section shall apply.

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

7 “(C) WAIVERS AND STATE PLAN AMEND-
8 MENTS.—

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

17 “(ii) REPLICATION OF WAIVER OR
18 AMENDMENT.—In designing a Medicaid
19 Flexibility Program, a State may mirror
20 provisions of a waiver or State plan
21 amendment described in clause (i) in the
22 program to the extent that such provisions
23 are otherwise consistent with the require-
24 ments of this section.

1 “(iii) EFFECT OF TERMINATION.—In
2 the case of a State described in clause (i)
3 that terminates its program under sub-
4 section (d)(2)(B), any waiver or amend-
5 ment which was limited pursuant to sub-
6 paragraph (A) shall cease to be so limited
7 effective with the effective date of such ter-
8 mination.

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

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

19 “(1) APPLICABLE PROGRAM ENROLLEE CAT-
20 EGORY.—The term ‘applicable program enrollee cat-
21 egory’ means, with respect to a State Medicaid
22 Flexibility Program for a program period, any of the
23 following as specified by the State for the period in
24 its application under subsection (b):

1 “(A) 2 ENROLLEE CATEGORIES.—Both of
2 the 1903A enrollee categories described in sub-
3 paragraphs (D) and (E) of section 1903A(e)(2).

4 “(B) EXPANSION ENROLLEES.—The
5 1903A enrollee category described in subpara-
6 graph (D) of section 1903A(e)(2).

7 “(C) NONELDERLY, NONDISABLED, NON-
8 EXPANSION ADULTS.—The 1903A enrollee cat-
9 egory described in subparagraph (E) of section
10 1903A(e)(2).

11 “(2) MEDICAID FLEXIBILITY PROGRAM.—The
12 term ‘Medicaid Flexibility Program’ means a State
13 program for providing targeted health assistance to
14 program enrollees funded by a block grant under
15 this section.

16 “(3) PROGRAM ENROLLEE.—

17 “(A) IN GENERAL.—The term ‘program
18 enrollee’ means, with respect to a State that is
19 conducting a Medicaid Flexibility Program for
20 a program period, an individual who is a 1903A
21 enrollee (as defined in section 1903A(e)(1)) who
22 is in the applicable program enrollee category
23 specified by the State for the period.

24 “(B) RULE OF CONSTRUCTION.—For pur-
25 poses of section 1903A(e)(3), eligibility and en-

1 rollment of an individual under a Medicaid
2 Flexibility Program shall be deemed to be eligi-
3 bility and enrollment under a State plan (or
4 waiver of such plan) under this title.

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

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

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

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

16 “(6) TARGETED HEALTH ASSISTANCE.—The
17 term ‘targeted health assistance’ means assistance
18 for health-care-related items and medical services for
19 program enrollees.”.

20 **SEC. 134. MEDICAID AND CHIP QUALITY PERFORMANCE**
21 **BONUS PAYMENTS.**

22 Section 1903 of the Social Security Act (42 U.S.C.
23 1396b), as amended by section 130, is further amended
24 by adding at the end the following new subsection:

25 “(bb) QUALITY PERFORMANCE BONUS PAYMENTS.—

1 “(1) INCREASED FEDERAL SHARE.—With re-
2 spect to each of fiscal years 2023 through 2026, in
3 the case of one of the 50 States or the District of
4 Columbia (each referred to in this subsection as a
5 ‘State’) that—

6 “(A) equals or exceeds the qualifying
7 amount (as established by the Secretary) of
8 lower than expected aggregate medical assist-
9 ance expenditures (as defined in paragraph (4))
10 for that fiscal year; and

11 “(B) submits to the Secretary, in accord-
12 ance with such manner and format as specified
13 by the Secretary and for the performance pe-
14 riod (as defined by the Secretary) for such fis-
15 cal year—

16 “(i) information on the applicable
17 quality measures identified under para-
18 graph (3) with respect to each category of
19 Medicaid eligible individuals under the
20 State plan or a waiver of such plan; and

21 “(ii) a plan for spending a portion of
22 additional funds resulting from application
23 of this subsection on quality improvement
24 within the State plan under this title or
25 under a waiver of such plan,

1 the Federal matching percentage otherwise ap-
2 plied under subsection (a)(7) for such fiscal
3 year shall be increased by such percentage (as
4 determined by the Secretary) so that the aggre-
5 gate amount of the resulting increase pursuant
6 to this subsection for the State and fiscal year
7 does not exceed the State allotment established
8 under paragraph (2) for the State and fiscal
9 year.

10 “(2) ALLOTMENT DETERMINATION.—The Sec-
11 retary shall establish a formula for computing State
12 allotments under this paragraph for each fiscal year
13 described in paragraph (1) such that—

14 “(A) such an allotment to a State is deter-
15 mined based on the performance, including im-
16 provement, of such State under this title and
17 title XXI with respect to the quality measures
18 submitted under paragraph (3) by such State
19 for the performance period (as defined by the
20 Secretary) for such fiscal year; and

21 “(B) the total of the allotments under this
22 paragraph for all States for the period of the
23 fiscal years described in paragraph (1) is equal
24 to \$8,000,000,000.

1 “(3) QUALITY MEASURES REQUIRED FOR
2 BONUS PAYMENTS.—For purposes of this subsection,
3 the Secretary shall, pursuant to rulemaking and
4 after consultation with State agencies administering
5 State plans under this title, identify and publish
6 (and update as necessary) peer-reviewed quality
7 measures (which shall include health care and long-
8 term care outcome measures and may include the
9 quality measures that are overseen or developed by
10 the National Committee for Quality Assurance or
11 the Agency for Healthcare Research and Quality or
12 that are identified under section 1139A or 1139B)
13 that are quantifiable, objective measures that take
14 into account the clinically appropriate measures of
15 quality for different types of patient populations re-
16 ceiving benefits or services under this title or title
17 XXI.

18 “(4) LOWER THAN EXPECTED AGGREGATE
19 MEDICAL ASSISTANCE EXPENDITURES.—In this sub-
20 section, the term ‘lower than expected aggregate
21 medical assistance expenditures’ means, with respect
22 to a State the amount (if any) by which—

23 “(A) the amount of the adjusted total med-
24 ical assistance expenditures for the State and
25 fiscal year determined in section 1903A(b)(1)

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

4 “(B) the amount of the target total med-
5 ical assistance expenditures for the State and
6 fiscal year determined in section 1903A(e) with-
7 out regard to the 1903A enrollee category de-
8 scribed in section 1903A(e)(2)(E).”.

9 **SEC. 135. GRANDFATHERING CERTAIN MEDICAID WAIVERS;**
10 **PRIORITIZATION OF HCBS WAIVERS.**

11 (a) **MANAGED CARE WAIVERS.—**

12 (1) **IN GENERAL.—**In the case of a State with
13 a grandfathered managed care waiver, the State
14 may, at its option through a State plan amendment,
15 continue to implement the managed care delivery
16 system that is the subject of such waiver in per-
17 petuity under the State plan under title XIX of the
18 Social Security Act (or a waiver of such plan) with-
19 out submitting an application to the Secretary for a
20 new waiver to implement such managed care delivery
21 system, so long as the terms and conditions of the
22 waiver involved (other than such terms and condi-
23 tions that relate to budget neutrality as modified
24 pursuant to section 1903A(f)(1) of the Social Secu-
25 rity Act) are not modified.

1 (2) MODIFICATIONS.—

2 (A) IN GENERAL.—If a State with a
3 grandfathered managed care waiver seeks to
4 modify the terms or conditions of such a waiv-
5 er, the State shall submit to the Secretary an
6 application for approval of a new waiver under
7 such modified terms and conditions.

8 (B) APPROVAL OF MODIFICATION.—

9 (i) IN GENERAL.—An application de-
10 scribed in subparagraph (A) is deemed ap-
11 proved unless the Secretary, not later than
12 90 days after the date on which the appli-
13 cation is submitted, submits to the State—

14 (I) a denial; or

15 (II) a request for more informa-
16 tion regarding the application.

17 (ii) ADDITIONAL INFORMATION.—If
18 the Secretary requests additional informa-
19 tion, the Secretary has 30 days after a
20 State submission in response to the Sec-
21 retary’s request to deny the application or
22 request more information.

23 (3) GRANDFATHERED MANAGED CARE WAIVER
24 DEFINED.—In this subsection, the term “grand-
25 fathered managed care waiver” means the provisions

1 of a waiver or an experimental, pilot, or demonstra-
2 tion project that relate to the authority of a State
3 to implement a managed care delivery system under
4 the State plan under title XIX of such Act (or under
5 a waiver of such plan under section 1115 of such
6 Act) that—

7 (A) is approved by the Secretary of Health
8 and Human Services under section 1915(b),
9 1932, or 1115(a)(1) of the Social Security Act
10 (42 U.S.C. 1396n(b), 1396u-2, 1315(a)(1)) as
11 of January 1, 2017; and

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

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

21 **SEC. 136. COORDINATION WITH STATES.**

22 Title XIX of the Social Security Act is amended by
23 inserting after section 1904 (42 U.S.C. 1396d) the fol-
24 lowing:

1 “COORDINATION WITH STATES

2 “SEC. 1904A. No proposed rule (as defined in section
3 551(4) of title 5, United States Code) implementing or
4 interpreting any provision of this title shall be finalized
5 on or after January 1, 2018, unless the Secretary—

6 “(1) provides for a process under which the
7 Secretary or the Secretary’s designee solicits advice
8 from each State’s State agency responsible for ad-
9 ministering the State plan under this title (or a
10 waiver of such plan) and State Medicaid Director—

11 “(A) on a regular, ongoing basis on mat-
12 ters relating to the application of this title that
13 are likely to have a direct effect on the oper-
14 ation or financing of State plans under this title
15 (or waivers of such plans); and

16 “(B) prior to submission of any final pro-
17 posed rule, plan amendment, waiver request, or
18 proposal for a project that is likely to have a di-
19 rect effect on the operation or financing of
20 State plans under this title (or waivers of such
21 plans);

22 “(2) accepts and considers written and oral
23 comments from a bipartisan, nonprofit, professional
24 organization that represents State Medicaid Direc-
25 tors, and from any State agency administering the

1 plan under this title, regarding such proposed rule;
2 and

3 “(3) incorporates in the preamble to the pro-
4 posed rule a summary of comments referred to in
5 paragraph (2) and the Secretary’s response to such
6 comments.”.

7 **SEC. 137. OPTIONAL ASSISTANCE FOR CERTAIN INPATIENT**
8 **PSYCHIATRIC SERVICES.**

9 (a) STATE OPTION.—Section 1905 of the Social Se-
10 curity Act (42 U.S.C. 1396d) is amended—

11 (1) in subsection (a)—

12 (A) in paragraph (16)—

13 (i) by striking “and, (B)” and insert-
14 ing “(B)”; and

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

22 (B) in the subdivision (B) that follows
23 paragraph (29), by inserting “(other than serv-
24 ices described in subparagraph (C) of para-
25 graph (16) for individuals described in such

1 subparagraph)” after “patient in an institution
2 for mental diseases”; and

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

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

11 “(A) in an institution (or distinct part thereof)
12 which is a psychiatric hospital (as defined in section
13 1861(f)); and

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

18 “(4) As a condition for a State including qualified
19 inpatient psychiatric hospital services as medical assist-
20 ance under subsection (a)(16)(C), the State must (during
21 the period in which it furnishes medical assistance under
22 this title for services and individuals described in such
23 subsection)—

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

1 contracted for by the State that were being main-
2 tained as of the date of the enactment of this para-
3 graph or, if higher, as of the date the State applies
4 to the Secretary to include medical assistance under
5 such subsection; and

6 “(B) maintain on an annual basis a level of
7 funding expended by the State (and political subdivi-
8 sions thereof) other than under this title from non-
9 Federal funds for inpatient services in an institution
10 described in paragraph (3)(A), and for active psy-
11 chiatric care and treatment provided on an out-
12 patient basis, that is not less than the level of such
13 funding for such services and care as of the date of
14 the enactment of this paragraph or, if higher, as of
15 the date the State applies to the Secretary to include
16 medical assistance under such subsection.”.

17 (b) SPECIAL MATCHING RATE.—Section 1905(b) of
18 the Social Security Act (42 U.S.C. 1395d(b)) is amended
19 by adding at the end the following: “Notwithstanding the
20 previous provisions of this subsection, the Federal medical
21 assistance percentage shall be 50 percent with respect to
22 medical assistance for services and individuals described
23 in subsection (a)(16)(C).”.

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

4 **SEC. 138. ENHANCED FMAP FOR MEDICAL ASSISTANCE TO**
5 **ELIGIBLE INDIANS.**

6 Section 1905(b) of the Social Security Act (42 U.S.C.
7 1396d(b)) is amended, in the third sentence, by inserting
8 “and with respect to amounts expended by a State as med-
9 ical assistance for services provided by any other provider
10 under the State plan to an individual who is a member
11 of an Indian tribe who is eligible for assistance under the
12 State plan” before the period.

13 **SEC. 139. MEDICAID OPTION TO PROVIDE CONSUMER-FO-**
14 **CUSED COST-SHARING ASSISTANCE FOR**
15 **LOW-INCOME INDIVIDUALS ENROLLING IN**
16 **QUALIFIED HEALTH PLANS.**

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

20 “CONSUMER-FOCUSED COST-SHARING ASSISTANCE FOR
21 LOW-INCOME INDIVIDUALS ENROLLING IN QUALI-
22 FIED HEALTH PLANS

23 “SEC. 1906B. (a) IN GENERAL.—A State may elect
24 to provide cost-sharing assistance (as defined in sub-
25 section (c)) for an eligible low-income individual (as de-
26 fined in subsection (b)) who is enrolled in a qualified

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

4 “(b) ELIGIBLE LOW-INCOME INDIVIDUAL DE-
5 FINED.—For purposes of this section, the term ‘eligible
6 low-income individual’ means an individual—

7 “(1) whose income (as determined under section
8 1902(e)(14)) does not exceed 133 percent of the
9 poverty line (as defined in section 2110(c)(5)) appli-
10 cable to a family of the size involved;

11 “(2) who is eligible for premium assistance for
12 the purchase of a qualified health plan under section
13 36B of the Internal Revenue Code of 1986 and is
14 enrolled in such a plan;

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

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

22 “(c) COST-SHARING ASSISTANCE DEFINED.—

23 “(1) IN GENERAL.—For purposes of this sec-
24 tion, the term ‘cost-sharing assistance’ includes
25 amounts expended for all or part of the costs of pre-

1 miums, deductibles, coinsurance, copayments, or
2 similar charges, and all or part of any amounts paid
3 for medical care (within the meaning of section
4 213(d) of the Internal Revenue Code of 1986).

5 “(2) OPTION OF ADDITIONAL BENEFITS.—Such
6 term may include, at the option of a State, such ad-
7 ditional benefits as the State may specify.

8 “(d) COST-EFFECTIVE DEFINED.—

9 “(1) IN GENERAL.—For purposes of this sec-
10 tion, with respect to a State and year, cost-sharing
11 assistance shall be considered to be ‘cost-effective’
12 with respect to a State if the aggregate amount of
13 Federal cost-sharing and premium assistance (as de-
14 fined in paragraph (2)) for the State and year do
15 not exceed the Federal cost-sharing assistance limit
16 (as defined in paragraph (3)) for the State and year.

17 “(2) AGGREGATE AMOUNT OF FEDERAL COST-
18 SHARING AND PREMIUM ASSISTANCE.—The term
19 ‘aggregate amount of Federal cost-sharing and pre-
20 mium assistance’ means, for a State and year, the
21 sum of—

22 “(A) the product of—

23 “(i) the Federal average medical as-
24 sistance matching percentage (as defined

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

3 “(ii) the amount of cost-sharing as-
4 sistance provided to eligible low-income in-
5 dividuals by the State for the year; and

6 “(B) the amount of Federal expenditures
7 attributable to advance payments for premium
8 tax credits under section 1412(c)(2) of the Pa-
9 tient Protection and Affordable Care Act made
10 on behalf of eligible low-income individuals in
11 the State for the year.

12 “(3) FEDERAL COST-SHARING ASSISTANCE
13 LIMIT.—The term ‘Federal cost-sharing assistance
14 limit’ means, for a State and year, the product of—

15 “(A) the Federal average medical assist-
16 ance matching percentage (as defined in section
17 1903A(a)(4)) for the State and year; and

18 “(B) the sum of the products, for each of
19 the 1903A enrollee categories described in sub-
20 paragraph (D) and (E) of section 1903A(e)(2),
21 of—

22 “(i) the target per capita medical as-
23 sistance expenditures for the State, year,
24 and category; and

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

5 “(e) OTHER PROVISIONS.—

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

11 “(A) notwithstanding section 1905(b), the
12 Federal medical assistance percentage applica-
13 ble to the total amount expended for such as-
14 sistance shall be equal to the Federal average
15 medical assistance matching percentage (as de-
16 fined in section 1903A(a)(4)) for such State
17 and year; and

18 “(B) in no case shall the amount of Fed-
19 eral payments made to a State for a year with
20 respect to amounts expended for such assist-
21 ance exceed the amount of the Federal cost-
22 sharing assistance limit for the State and year
23 applicable under subsection (d)(3).

24 “(2) SCALING OF ASSISTANCE.—A State may
25 provide cost-sharing assistance under this section on

1 a sliding scale based on income and percentage of
2 full actuarial value that the State may determine.

3 “(3) NOT CONSIDERED MINIMUM ESSENTIAL
4 COVERAGE.—Cost-sharing assistance provided under
5 this section shall not be considered to be minimum
6 essential coverage (as defined in section 5000A(f) of
7 the Internal Revenue Code of 1986).

8 “(4) NONAPPLICATION OF OTHER REQUIRE-
9 MENTS.—Sections 1902(a)(1) (relating to
10 statewideness), 1902(a)(10)(B) (relating to com-
11 parability), 1916, and 1916A (relating to cost-shar-
12 ing for medical assistance), and any other provision
13 of this title which would be directly contrary to the
14 authority under this section shall not apply to the
15 provision of cost-sharing assistance under this sec-
16 tion.”.

17 **SEC. 140. SMALL BUSINESS HEALTH PLANS.**

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

22 (1) as a group health plan (as defined in sec-
23 tion 2791 of the Public Health Service Act (42
24 U.S.C. 300gg-91)) for purposes of applying title
25 XXVII of the Public Health Service Act (42 U.S.C.

1 300gg et seq.) and title XXII of such Act (42
2 U.S.C. 300bb-1);

3 (2) as a group health plan (as defined in sec-
4 tion 5000(b)(1) of the Internal Revenue Code of
5 1986) for purposes of applying sections 4980B and
6 5000 and chapter 100 of the Internal Revenue Code
7 of 1986; and

8 (3) as a group health plan (as defined in sec-
9 tion 733(a)(1) of the Employee Retirement Income
10 Security Act of 1974 (29 U.S.C. 1191b(a)(1))) for
11 purposes of applying parts 6 and 7 of title I of the
12 Employee Retirement Income Security Act of 1974
13 (29 U.S.C. 1161 et seq.).

14 (b) RULES.—Subtitle B of title I of the Employee
15 Retirement Income Security Act of 1974 (29 U.S.C. 1021
16 et seq.) is amended by adding at the end the following
17 new part:

18 **“PART 8—RULES GOVERNING SMALL BUSINESS**

19 **RISK SHARING POOLS**

20 **“SEC. 801. SMALL BUSINESS HEALTH PLANS.**

21 “(a) IN GENERAL.—For purposes of this part, the
22 term ‘small business health plan’ means a fully insured
23 group health plan, offered by a health insurance issuer in
24 the large group market, whose sponsor is described in sub-
25 section (b).

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

3 “(1) is a qualified sponsor and receives certifi-
4 cation by the Secretary;

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

9 “(3) is established as a permanent entity;

10 “(4) is established for a purpose other than
11 providing health benefits to its members, such as an
12 organization established as a bona fide trade asso-
13 ciation, franchise, or section 7705 organization; and

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

16 **“SEC. 802. FILING FEE AND CERTIFICATION OF SMALL**
17 **BUSINESS HEALTH PLANS.**

18 “(a) FILING FEE.—A small business health plan
19 shall pay to the Secretary at the time of filing an applica-
20 tion for certification under subsection (b) a filing fee in
21 the amount of \$5,000, which shall be available to the Sec-
22 retary for the sole purpose of administering the certifi-
23 cation procedures applicable with respect to small business
24 health plans.

25 “(b) CERTIFICATION.—

1 “(1) IN GENERAL.—Not later than 6 months
2 after the date of enactment of this part, the Sec-
3 retary shall prescribe by interim final rule a proce-
4 dure under which the Secretary—

5 “(A) will certify a qualified sponsor of a
6 small business health plan, upon receipt of an
7 application that includes the information de-
8 scribed in paragraph (2);

9 “(B) may provide for continued certifi-
10 cation of small business health plans under this
11 part;

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

17 “(D) shall conduct oversight of certified
18 plan sponsors, including periodic review, and
19 consistent with section 504, applying the re-
20 quirements of sections 518, 519, and 520; and

21 “(E) will consult with a State with respect
22 to a small business health plan domiciled in
23 such State regarding the Secretary’s authority
24 under this part and other enforcement author-
25 ity under sections 502 and 504.

1 “(2) INFORMATION TO BE INCLUDED IN APPLI-
2 CATION FOR CERTIFICATION.—An application for
3 certification under this part meets the requirements
4 of this section only if it includes, in a manner and
5 form which shall be prescribed by the applicable au-
6 thority by regulation, at least the following informa-
7 tion:

8 “(A) Identifying information.

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

11 “(C) Bonding requirements.

12 “(D) Plan documents.

13 “(E) Agreements with service providers.

14 “(3) REQUIREMENTS FOR CERTIFIED PLAN
15 SPONSORS.—Not later than 6 months after the date
16 of enactment of this part, the Secretary shall pre-
17 scribe by interim final rule requirements for certified
18 plan sponsors that include requirements regarding—

19 “(A) structure and requirements for
20 boards of trustees or plan administrators;

21 “(B) notification of material changes; and

22 “(C) notification for voluntary termination.

23 “(c) FILING NOTICE OF CERTIFICATION WITH
24 STATES.—A certification granted under this part to a
25 small business health plan shall not be effective unless

1 written notice of such certification is filed by the plan
2 sponsor with the applicable State authority of each State
3 in which the small business health plan operates.

4 “(d) EXPEDITED AND DEEMED CERTIFICATION.—

5 “(1) IN GENERAL.—If the Secretary fails to act
6 on a complete application for certification under this
7 section within 90 days of receipt of such complete
8 application, the applying small business health plan
9 sponsor shall be deemed certified until such time as
10 the Secretary may deny for cause the application for
11 certification.

12 “(2) PENALTY.—The Secretary may assess a
13 penalty against the board of trustees, plan adminis-
14 trator, and plan sponsor (jointly and severally) of a
15 small business health plan sponsor that is deemed
16 certified under paragraph (1) of up to \$500,000 in
17 the event the Secretary determines that the applica-
18 tion for certification of such small business health
19 plan sponsor was willfully or with gross negligence
20 incomplete or inaccurate.

21 **“SEC. 803. PARTICIPATION AND COVERAGE REQUIRE-**
22 **MENTS.**

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

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

3 “(1) each participating employer must be—

4 “(A) a member of the sponsor;

5 “(B) the sponsor; or

6 “(C) an affiliated member of the sponsor,
7 except that, in the case of a sponsor which is
8 a professional association or other individual-
9 based association, if at least one of the officers,
10 directors, or employees of an employer, or at
11 least one of the individuals who are partners in
12 an employer and who actively participates in
13 the business, is a member or such an affiliated
14 member of the sponsor, participating employers
15 may also include such employer; and

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

19 “(A) active or retired owners (including
20 self-employed individuals with or without em-
21 ployees), officers, directors, or employees of, or
22 partners in, participating employers; or

23 “(B) the dependents of individuals de-
24 scribed in subparagraph (A).

1 “(b) PARTICIPATING EMPLOYERS.—In applying re-
2 quirements relating to coverage renewal, a participating
3 employer shall not be deemed to be a plan sponsor.

4 “(c) PROHIBITION OF DISCRIMINATION AGAINST EM-
5 PLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—
6 The requirements of this subsection are met with respect
7 to a small business health plan if—

8 “(1) under the terms of the plan, no partici-
9 pating employer may provide health insurance cov-
10 erage in the individual market for any employee not
11 covered under the plan, if such exclusion of the em-
12 ployee from coverage under the plan is based on a
13 health status-related factor with respect to the em-
14 ployee and such employee would, but for such exclu-
15 sion on such basis, be eligible for coverage under the
16 plan; and

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

20 **“SEC. 804. DEFINITIONS; RENEWAL.**

21 “For purposes of this part:

22 “(1) AFFILIATED MEMBER.—The term ‘affili-
23 ated member’ means, in connection with a sponsor—

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

4 “(B) in the case of a sponsor with mem-
5 bers which consist of associations, a person who
6 is a member or employee of any such associa-
7 tion and elects an affiliated status with the
8 sponsor.

9 “(2) APPLICABLE STATE AUTHORITY.—The
10 term ‘applicable State authority’ means, with respect
11 to a health insurance issuer in a State, the State in-
12 surance commissioner or official or officials des-
13 ignated by the State to enforce the requirements of
14 title XXVII of the Public Health Service Act for the
15 State involved with respect to such issuer.

16 “(3) FRANCHISOR; FRANCHISEE.—The terms
17 ‘franchisor’ and ‘franchisee’ have the meanings given
18 such terms for purposes of sections 436.2(a)
19 through 436.2(c) of title 16, Code of Federal Regu-
20 lations (including any such amendments to such regu-
21 lation after the date of enactment of this part) and,
22 for purposes of this part, franchisor or franchisee
23 employers participating in such a group health plan
24 shall not be treated as the employer, co-employer, or
25 joint employer of the employees of another partici-

1 pating franchisor or franchisee employer for any
2 purpose.

3 “(4) HEALTH PLAN TERMS.—The terms ‘group
4 health plan’, ‘health insurance coverage’, and ‘health
5 insurance issuer’ have the meanings given such
6 terms in section 733.

7 “(5) INDIVIDUAL MARKET.—

8 “(A) IN GENERAL.—The term ‘individual
9 market’ means the market for health insurance
10 coverage offered to individuals other than in
11 connection with a group health plan.

12 “(B) TREATMENT OF VERY SMALL
13 GROUPS.—

14 “(i) IN GENERAL.—Subject to clause
15 (ii), such term includes coverage offered in
16 connection with a group health plan that
17 has fewer than 2 participants as current
18 employees or participants described in sec-
19 tion 732(d)(3) on the first day of the plan
20 year.

21 “(ii) STATE EXCEPTION.—Clause (i)
22 shall not apply in the case of health insur-
23 ance coverage offered in a State if such
24 State regulates the coverage described in
25 such clause in the same manner and to the

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

5 “(6) PARTICIPATING EMPLOYER.—The term
6 ‘participating employer’ means, in connection with a
7 small business health plan, any employer, if any in-
8 dividual who is an employee of such employer, a
9 partner in such employer, or a self-employed indi-
10 vidual who is such employer with or without employ-
11 ees (or any dependent, as defined under the terms
12 of the plan, of such individual) is or was covered
13 under such plan in connection with the status of
14 such individual as such an employee, partner, or
15 self-employed individual in relation to the plan.

16 “(7) SECTION 7705 ORGANIZATION.—The term
17 ‘section 7705 organization’ means an organization
18 providing services for a customer pursuant to a con-
19 tract meeting the conditions of subparagraphs (A),
20 (B), (C), (D), and (E) (but not (F)) of section
21 7705(e)(2) of the Internal Revenue Code of 1986,
22 including an entity that is part of a section 7705 or-
23 ganization control group . For purposes of this part,
24 any reference to ‘member’ shall include a customer
25 of a section 7705 organization except with respect to

1 references to a ‘member’ or ‘members’ in paragraph
2 (1).”.

3 (c) PREEMPTION RULES.—Section 514 of the Em-
4 ployee Retirement Income Security Act of 1974 (29
5 U.S.C. 1144) is amended by adding at the end the fol-
6 lowing:

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

12 (d) PLAN SPONSOR.—Section 3(16)(B) of such Act
13 (29 U.S.C. 102(16)(B)) is amended by adding at the end
14 the following new sentence: “Such term also includes a
15 person serving as the sponsor of a small business health
16 plan under part 8.”.

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

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

TITLE II

1

2 SEC. 201. THE PREVENTION AND PUBLIC HEALTH FUND.

3 Subsection (b) of section 4002 of the Patient Protec-
4 tion and Affordable Care Act (42 U.S.C. 300u-11) is
5 amended—

6 (1) in paragraph (3), by striking “each of fiscal
7 years 2018 and 2019” and inserting “fiscal year
8 2018”; and

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

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

12 There is authorized to be appropriated, and is appro-
13 priated, to the Secretary of Health and Human Services,
14 out of monies in the Treasury not otherwise obligated—

15 (1) \$4,972,000,000 for each of fiscal years
16 2018 through 2026, to provide grants to States to
17 support substance use disorder treatment and recov-
18 ery support services for individuals who have or may
19 have mental or substance use disorders, including
20 counseling, medication assisted treatment, and other
21 substance abuse treatment and recovery services as
22 such Secretary determines appropriate; and

23 (2) \$50,400,000 for each of fiscal years 2018
24 through 2022, for research on addiction and pain re-
25 lated to the substance abuse crisis.

1 Funds appropriated under this section shall remain avail-
2 able until expended.

3 **SEC. 203. COMMUNITY HEALTH CENTER PROGRAM.**

4 Effective as if included in the enactment of the Medi-
5 care Access and CHIP Reauthorization Act of 2015 (Pub-
6 lic Law 114–10, 129 Stat. 87), paragraph (1) of section
7 221(a) of such Act is amended by inserting “, and an ad-
8 ditional \$422,000,000 for fiscal year 2017” after “2017”.

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

11 Section 2701(a)(1)(A)(iii) of the Public Health Serv-
12 ice Act (42 U.S.C. 300gg(a)(1)(A)(iii)) is amended by in-
13 serting after “(consistent with section 2707(c))” the fol-
14 lowing: “or, for plan years beginning on or after January
15 1, 2019, 5 to 1 for adults (consistent with section 2707(c))
16 or such other ratio for adults (consistent with section
17 2707(c)) as the State may determine”.

18 **SEC. 205. MEDICAL LOSS RATIO DETERMINED BY THE**
19 **STATE.**

20 Section 2718(b) of the Public Health Service Act (42
21 U.S.C. 300gg–18(b)) is amended by adding at the end the
22 following:

23 “(4) SUNSET.—Paragraphs (1) through (3) and
24 subsection (d) shall not apply for plan years begin-
25 ning on or after January 1, 2019, and after such

1 date any reference in law to such paragraphs and
2 subsection shall have no force or effect.

3 “(5) MEDICAL LOSS RATIO DETERMINED BY
4 THE STATE.—For plan years beginning on or after
5 January 1, 2019, each State shall—

6 “(A) set the ratio of the amount of pre-
7 mium revenue a health insurance issuer offering
8 group or individual health insurance coverage
9 may expend on non-claims costs to the total
10 amount of premium revenue; and

11 “(B) determine the amount of any annual
12 rebate required to be paid to enrollees under
13 such coverage if the ratio of the amount of pre-
14 mium revenue expended by the issuer on non-
15 claims costs to the total amount of premium
16 revenue exceeds the ratio set by the State under
17 subparagraph (A).”.

18 **SEC. 206. STABILIZING THE INDIVIDUAL INSURANCE MAR-**

19 **KETS.**

20 (a) ENROLLMENT WAITING PERIODS.—Section
21 2702(b)(1) of the Public Health Services Act (42 U.S.C.
22 300gg-1(b)(1)) is amended by inserting “, and as de-
23 scribed in paragraph (3)” before the period.

24 (b) CREDITABLE COVERAGE REQUIREMENT.—Sec-
25 tion 2702(b)(2) of the Public Health Services Act (42

1 U.S.C. 300gg–1(b)(2)) is amended by striking “paragraph
2 (3)” and inserting “paragraph (4)”.

3 (c) APPLICATION OF WAITING PERIODS.—Section
4 2702(b) of the Public Health Services Act (42 U.S.C.
5 300gg-1(b)) is amended—

6 (1) in paragraph (3)—

7 (A) by striking “with respect to enrollment
8 periods under paragraphs (1) and (2)”, insert-
9 ing “in accordance with this subsection”; and

10 (B) by redesignating such paragraph as
11 paragraph (4); and

12 (2) by inserting after paragraph (2), the fol-
13 lowing:

14 “(3) WAITING PERIODS.—

15 “(A) IN GENERAL.—With respect to health
16 insurance coverage that is effective on or after
17 January 1, 2019, a health insurance issuer de-
18 scribed in subsection (a) that offers such cov-
19 erage in the individual market shall impose a 6
20 month waiting period (as defined in the same
21 manner as such term is defined in section
22 2704(b)(4) for group health plans) on any indi-
23 vidual who enrolls in such coverage and who
24 cannot demonstrate—

1 “(i) in the case of an individual sub-
2 mitting an application during an open en-
3 rollment period, 12 months of continuous
4 creditable coverage without experiencing a
5 significant break in such coverage as de-
6 scribed in subparagraphs (A) and (B) of
7 section 2704(c)(2); or

8 “(ii) in the case of an individual sub-
9 mitting an application during a special en-
10 rollment period—

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

14 “(II) at least 1 day of creditable
15 coverage during the 60-day period im-
16 mediately preceding the date of sub-
17 mission of such application.

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

24 “(C) WAITING PERIOD DESCRIBED.—For
25 purposes of subparagraph (A)—

1 “(i) in the case of an individual that
2 submits an application during an open en-
3 rollment period or under a special enroll-
4 ment period for which the individual quali-
5 fies, coverage under the plan begins on the
6 first day of the first month that begins 6
7 months after the date on which the indi-
8 vidual submits an application for health in-
9 surance coverage; and

10 “(ii) in the case of an individual that
11 submits an application outside of an open
12 enrollment period and does not qualify for
13 enrollment under a special enrollment pe-
14 riod, coverage under the plan begins on the
15 later of—

16 “(I) the first day of the first
17 month that begins 6 months after the
18 day on which the individual submits
19 an application for health insurance
20 coverage; or

21 “(II) the first day of the next
22 plan year.

23 “(D) CERTIFICATES OF CREDITABLE COV-
24 ERAGE.—The Secretary shall require health in-
25 surance issuers and health care sharing min-

1 istries (as defined in section 5000A(d)(2)(B) of
2 the Internal Revenue Code of 1986) to provide
3 certification of periods of creditable coverage
4 and waiting periods, in a manner prescribed by
5 the Secretary, for purposes of verifying that the
6 continuous coverage requirements of subpara-
7 graph (A) are met.

8 “(E) CONTINUOUS CREDITABLE COVERAGE
9 DEFINED.—For purposes of this paragraph, the
10 term ‘creditable coverage’—

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

13 “(ii) includes membership in a health
14 care sharing ministry (as defined in section
15 5000A(d)(2)(B) of the Internal Revenue
16 Code of 1986).

17 “(F) EXCEPTIONS.—Notwithstanding sub-
18 paragraph (A), a health insurance issuer may
19 not impose a waiting period with respect to the
20 following individuals:

21 “(i) A newborn who is enrolled in
22 such coverage within 30 days of the date
23 of birth.

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

1 age and who is enrolled in such coverage
2 within 30 days of the date of the adoption.

3 “(iii) Other individuals, as the Sec-
4 retary determines appropriate.”.

5 **SEC. 207. WAIVERS FOR STATE INNOVATION.**

6 (a) IN GENERAL.—Section 1332 of the Patient Pro-
7 tection and Affordable Care Act (42 U.S.C. 18052) is
8 amended—

9 (1) in subsection (a)—

10 (A) in paragraph (1)—

11 (i) in subparagraph (B)—

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

14 “(i) a description of how the State
15 plan meeting the requirements of a waiver
16 under this section would, with respect to
17 health insurance coverage within the
18 State—

19 “(I) take the place of the require-
20 ments described in paragraph (2) that
21 are waived; and

22 “(II) provide for alternative
23 means of, and requirements for, in-
24 creasing access to comprehensive cov-
25 erage, reducing average premiums,

1 providing consumers the freedom to
2 purchase the health insurance of their
3 choice, and increasing enrollment in
4 private health insurance; and”;

5 (II) in clause (ii), by striking
6 “that is budget neutral for the Fed-
7 eral Government” and inserting “,
8 demonstrating that the State plan
9 does not increase the Federal deficit”;
10 and

11 (ii) in subparagraph (C), by striking
12 “the law” and inserting “a law or has in
13 effect a certification”;

14 (B) in paragraph (3)—

15 (i) in the first sentence, by inserting
16 “or would qualify for a reduction in” after
17 “would not qualify for”;

18 (ii) by adding after the second sen-
19 tence the following: “A State may request
20 that all of, or any portion of, such aggre-
21 gate amount of such credits or reductions
22 be paid to the State as described in the
23 first sentence.”;

1 (iii) in the paragraph heading, by
2 striking “PASS THROUGH OF FUNDING”
3 and inserting “FUNDING”;

4 (iv) by striking “With respect” and
5 inserting the following:

6 “(A) PASS THROUGH OF FUNDING.—With
7 respect”; and

8 (v) by adding at the end the following:

9 “(B) ADDITIONAL FUNDING.—There is au-
10 thorized to be appropriated, and is appro-
11 priated, to the Secretary of Health and Human
12 Services, out of monies in the Treasury not oth-
13 erwise obligated, \$2,000,000,000 for fiscal year
14 2017, to remain available until the end of fiscal
15 year 2019, to provide grants to States for pur-
16 poses of submitting an application for a waiver
17 granted under this section and implementing
18 the State plan under such waiver.

19 “(C) AUTHORITY TO USE LONG-TERM
20 STATE INNOVATION AND STABILITY ALLOT-
21 MENT.—If the State has an application for an
22 allotment under section 2105(i) of the Social
23 Security Act for the plan year, the State may
24 use the funds available under the State’s allot-
25 ment for the plan year to carry out the State

1 plan under this section, so long as such use is
2 consistent with the requirements of paragraphs
3 (1) and (7) of section 2105(i) of such Act
4 (other than paragraph (1)(B) of such section).
5 Any funds used to carry out a State plan under
6 this subparagraph shall not be considered in de-
7 termining whether the State plan increases the
8 Federal deficit.”; and

9 (C) in paragraph (4), by adding at the end
10 the following:

11 “(D) EXPEDITED PROCESS.—The Sec-
12 retary shall establish an expedited application
13 and approval process that may be used if the
14 Secretary determines that such expedited proc-
15 ess is necessary to respond to an urgent or
16 emergency situation with respect to health in-
17 surance coverage within a State.”;

18 (2) in subsection (b)—

19 (A) in paragraph (1)—

20 (i) in the matter preceding subpara-
21 graph (A)—

22 (I) by striking “may” and insert-
23 ing “shall”; and

24 (II) by striking “only if” and in-
25 serting “unless”; and

1 (ii) by striking “plan—” and all that
2 follows through the period at the end of
3 subparagraph (D) and inserting “applica-
4 tion is missing a required element under
5 subsection (a)(1) or that the State plan
6 will increase the Federal deficit, not taking
7 into account any amounts received through
8 a grant under subsection (a)(3)(B).”;
9 (B) in paragraph (2)—

10 (i) in the paragraph heading, by in-
11 serting “OR CERTIFY” after “LAW”;

12 (ii) in subparagraph (A), by inserting
13 before the period “, and a certification de-
14 scribed in this paragraph is a document,
15 signed by the Governor, and the State in-
16 surance commissioner, of the State, that
17 provides authority for State actions under
18 a waiver under this section, including the
19 implementation of the State plan under
20 subsection (a)(1)(B)”;

21 (iii) in subparagraph (B)—

22 (I) in the subparagraph heading,
23 by striking “OF OPT OUT”; and

24 (II) by striking “ may repeal a
25 law” and all that follows through the

1 period at the end and inserting the
2 following: “may terminate the author-
3 ity provided under the waiver with re-
4 spect to the State by—

5 “(i) repealing a law described in sub-
6 paragraph (A); or

7 “(ii) terminating a certification de-
8 scribed in subparagraph (A), through a
9 certification for such termination signed by
10 the Governor, and the State insurance
11 commissioner, of the State.”;

12 (3) in subsection (d)(2)(B), by striking “and
13 the reasons therefore” and inserting “and the rea-
14 sons therefore, and provide the data on which such
15 determination was made”; and

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

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

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

1 “(3) may not be cancelled by the Secretary be-
2 fore the expiration of the 8-year period (including
3 any renewal period under paragraph (2)).”.

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

7 (1) In the case of a State for which a waiver
8 under such section was granted prior to the date of
9 enactment of this Act, such section 1332, as in ef-
10 fect on the day before the date of enactment of this
11 Act shall apply to the waiver and State plan.

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

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

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

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

8 “(4) CONSUMER FREEDOM.—For plan years be-
9 ginning on or after January 1, 2019, paragraph
10 (1)(A) shall not apply with respect to any plan of-
11 fered in the State.”.

12 (b) RISK POOLS.—Section 1312(e) of the Patient
13 Protection and Affordable Care Act (42 U.S.C. 18032(e))
14 is amended—

15 (1) in paragraph (1), by inserting “and includ-
16 ing, with respect to plan years beginning on or after
17 January 1, 2019, enrollees in catastrophic plans de-
18 scribed in section 1302(e)” after “Exchange”; and

19 (2) in paragraph (2), by inserting “and includ-
20 ing, with respect to plan years beginning on or after
21 January 1, 2019, enrollees in catastrophic plans de-
22 scribed in section 1302(e)” after “Exchange”.

23 **SEC. 209. APPLICATION OF ENFORCEMENT PENALTIES.**

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

26 (1) in subsection (a)—

1 (A) in paragraph (1), by inserting “and of
2 section 1303 of the Patient Protection and Af-
3 fordable Care Act” after “this part”; and

4 (B) in paragraph (2), by inserting “or in
5 such section 1303” after “this part”; and

6 (2) in subsection (b)—

7 (A) in paragraphs (1) and (2)(A), by in-
8 serting “or section 1303 of the Patient Protec-
9 tion and Affordable Care Act” after “this part”
10 each place such term appears;

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

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

19 **SEC. 210. FUNDING FOR COST-SHARING PAYMENTS.**

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

1 the period beginning on the date of enactment of this Act
2 and ending on December 31, 2019. Notwithstanding any
3 other provision of this Act, payments and other actions
4 for adjustments to any obligations incurred for plan years
5 2018 and 2019 may be made through December 31, 2020.

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

7 (a) IN GENERAL.—Section 1402 of the Patient Pro-
8 tection and Affordable Care Act is repealed.

9 (b) EFFECTIVE DATE.—The repeal made by sub-
10 section (a) shall apply to cost-sharing reductions (and pay-
11 ments to issuers for such reductions) for plan years begin-
12 ning after December 31, 2019.

13 **SEC. 212. CONDITIONS FOR RECEIVING ADDITIONAL SUP-**
14 **PORT FOR STABILIZING PREMIUMS AND PRO-**
15 **MOTING CHOICE IN PLANS OFFERED IN THE**
16 **INDIVIDUAL MARKET.**

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

1 300gg(a)(2)), the provisions described in subsection (c)
2 shall be treated as not applying (directly or through ref-
3 erence) for those plan years to health insurance coverage
4 offered off the Exchange by such issuer in the individual
5 market in the rating area in the State for such plan year
6 (other than with respect to health insurance coverage cer-
7 tified under subsection (b)(2)), provided that such cov-
8 erage offered off the Exchange complies with the applica-
9 ble State health insurance requirements.

10 (b) CONDITIONS FOR FEDERAL FUNDING FOR
11 PLANS.—The conditions of this subsection for a health in-
12 surance issuer for a plan year are that the health insur-
13 ance issuer, on or before May 3 of the calendar year pre-
14 ceding the plan year involved—

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

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

1 18022(d)(1)) and one health plan that provides the
2 level of coverage described in section
3 36B(b)(3)(B)(i) of the Internal Revenue Code of
4 1986.

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

7 (1) Subsections (b), (c)(1)(B), and (d) of sec-
8 tion 1302 of the Patient Protection and Affordable
9 Care Act (42 U.S.C. 18022).

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

12 (3) Subsections (a) and (b)(2) of section 2702
13 of the Public Health Service Act (42 U.S.C. §§
14 300gg-1).

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

17 (5) Subsections (a) through (j) of section 2705
18 of the Public Health Service Act (42 U.S.C. §§
19 300gg-4).

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

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

24 (8) Section 2713(a) of the Public Health Serv-
25 ice Act (42 U.S.C. 300gg-13(a)).

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

3 (d) CONTINUOUS COVERAGE.—For purposes of sec-
4 tion 2702(b) of the Public Health Service Act (42 U.S.C.
5 300gg–1), health insurance coverage offered off the Ex-
6 change in accordance with subsection (a) shall not be
7 deemed creditable coverage, as defined in section 2704(c)
8 of the Public Health Service Act (42 U.S.C. 300gg–3(c)).

9 (e) NONAPPLICATION OF RISK ADJUSTMENT PRO-
10 GRAM.—Section 1343 of the Patient Protection and Af-
11 fordable Care Act (42 U.S.C. 18063) shall not apply to
12 health insurance coverage offered off the Exchange in ac-
13 cordance with subsection (a) or to the issuer of such cov-
14 erage with respect to that coverage.

15 (f) EFFECT OF WAIVER.—A State that receives a
16 waiver under section 1332 of the Patient Protection and
17 Affordable Care Act (42 U.S.C. 18052) shall not be per-
18 mitted to use pass through funding under subsection
19 (a)(3)(C) of such section either to provide assistance to
20 individuals who enroll in health insurance coverage offered
21 in accordance with subsection (a) or to make payments
22 to issuers for any health insurance coverage offered in ac-
23 cordance with subsection (a).

24 (g) FUNDING FOR STATES.—

1 (1) APPROPRIATION.—There is appropriated to
2 the Secretary of Health and Human Services, out of
3 any money in the Treasury not otherwise appro-
4 priated, \$2,000,000,000 for the period beginning on
5 January 1, 2020, and ending on December 31,
6 2026, for the purpose of providing allotments for
7 States in which a health insurance issuer offers cov-
8 erage in accordance with subsection (a). Amounts
9 paid to any such State from such an allotment shall
10 be used to offset costs attributable to the State’s
11 regulation and oversight of such coverage. Funds ap-
12 propriated under this paragraph shall remain avail-
13 able until expended.

14 (2) PROCEDURE FOR DISTRIBUTION OF
15 FUNDS.—The Secretary of Health and Human Serv-
16 ices shall determine an appropriate procedure for
17 providing and distributing funds under this sub-
18 section.

19 (h) TAX CREDIT NOT AVAILABLE.—Health insur-
20 ance coverage offered off the Exchange in accordance with
21 subsection (a) shall not be taken into account as a quali-
22 fied health plan for purposes of calculating the amount
23 of the premium tax credit under section 36B of the Inter-
24 nal Revenue Code of 1986.