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115TH CONGRESS
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H. R. 1628

IN THE SENATE OF THE UNITED STATES

JUNE 7, 2017
Received; read the first time

JUNE 8, 2017
Read twice and placed on the calendar

AN ACT

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''American Health Care Act of 2017''.

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

TITLE I—ENERGY AND COMMERCE

Subtitle A—Patient Access to Public Health Programs

SEC. 101. THE PREVENTION AND PUBLIC HEALTH FUND.

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

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

(2) in paragraph (3)—

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

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

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

(b) RESCISSION OF UNOBLIGATED FUNDS.—Of the funds made available by such section 4002, the unobligated balance at the end of fiscal year 2018 is rescinded.

SEC. 102. COMMUNITY HEALTH CENTER PROGRAM.

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

SEC. 103. FEDERAL PAYMENTS TO STATES.

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

ited entity or through a managed care organization under contract with the State.

(b) DEFINITIONS.—In this section:

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

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

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

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

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

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

(II) in the case where a woman suffers from a physical disorder, phys-

ical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself; and

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

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

Subtitle B—Medicaid Program Enhancement

SEC. 111. REPEAL OF MEDICAID PROVISIONS.

The Social Security Act is amended—

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

(A) in subsection (a)(47)(B), by inserting ''and provided that any such election shall cease to be effective on January 1, 2020, and no such election shall be made after that date'' before the semicolon at the end; and

(B) in subsection (l)(2)(C), by inserting ''and ending December 31, 2019,'' after ''January 1, 2014,'';

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

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

SEC. 112. REPEAL OF MEDICAID EXPANSION.

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

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

(A) in subsection (a)(10)(A)—

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

(ii) in clause (ii)(XX), by inserting ''and ending December 31, 2017,'' after ''2014,''; and

(iii) in clause (ii), by adding at the end the following new subclause:

''(XXIII) beginning January 1, 2020—

''(aa) who are expansion enrollees (as defined in subsection (nn)(1)); or

''(bb) who are grandfathered expansion enrollees (as defined in subsection (nn)(2));''; and

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

''(nn) EXPANSION ENROLLEES.—In this title:

''(1) IN GENERAL.—The term 'expansion enrollee' means an individual—

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

''(B) who is not pregnant;

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

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

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

''(2) GRANDFATHERED EXPANSION ENROLLEES.—The term 'grandfathered expansion enrollee' means an expansion enrollee who—

''(A) was enrolled under the State plan under this title (or under a waiver of such plan) as of December 31, 2019; and

''(B) does not have a break in eligibility for medical assistance under such State plan (or waiver) for more than one month after such date.

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

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

(A) in subsection (y)(1), in the matter preceding subparagraph (A)—

(i) by inserting ''and that has elected to cover newly eligible individuals before March 1, 2017'' after ''that is one of the 50 States or the District of Columbia''; and

(ii) by inserting after ''subclause (VIII) of section 1902(a)(10)(A)(i)'' the following: ''who, for periods after December 31, 2019, are grandfathered expansion enrollees (as defined in section 1902(nn)(2))''; and

(B) in subsection (z)(2)—

(i) in subparagraph (A), by inserting after ''section 1937'' the following: ''and, for periods after December 31, 2019, who are grandfathered expansion enrollees (as defined in section 1902(nn)(2))''; and

(ii) in subparagraph (B)(ii)—

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

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

"(IV) 2017 and each subsequent year is 80 percent.".

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

SEC. 113. ELIMINATION OF DSH CUTS.

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

(1) in paragraph (7)—

(A) in subparagraph (A)—

(i) in clause (i)—

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

(ii) in clause (ii)—

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

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

(III) by striking subclauses (III) through (VIII); and

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

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

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

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

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

''(I) The term 'expansion State' means with respect to a fiscal year, a State that, as of July 1 of the preceding fiscal year, provides for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) for

medical assistance under this title (or a waiver of the State plan approved under section 1115).

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

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

SEC. 114. REDUCING STATE MEDICAID COSTS.

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

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

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

(B) in subsection (e)—

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

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

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

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

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

"(III) over a period of 3 months if the amount of such winnings or income (as applicable) is greater than or

equal to $90,000 but less than $100,000; and

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

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

"(iii) HARDSHIP EXEMPTION.—An individual whose income, by application of clause (i), exceeds the applicable eligibility threshold established by the State, may continue to be eligible for medical assistance to the extent that the State determines, under procedures established by the

State under the State plan (or in the case of a waiver of the plan under section 1115, incorporated in such waiver), or as otherwise established by such State in accordance with such standards as may be specified by the Secretary, that the denial of eligibility of the individual would cause an undue medical or financial hardship as determined on the basis of criteria established by the Secretary.

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

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

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

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

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

(ii) by striking ''(14) EXCLUSION'' and inserting ''(15) EXCLUSION''.

(2) RULES OF CONSTRUCTION.—

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

(B) APPLICABILITY LIMITED TO ELIGIBILITY OF RECIPIENT OF LOTTERY WINNINGS OR LUMP SUM INCOME.—Nothing in the amendment made by paragraph (1)(B)(i) shall be construed, with respect to a determination of household income for purposes of a determination of eligibility for medical assistance under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan) made by applying modified adjusted gross income under subparagraph (A) of section 1902(e)(14) of such Act (42 U.S.C. 1396a(e)(14)), as limiting the eligibility for

such medical assistance of any individual that is a member of the household other than the individual (or the individual's spouse) who received qualified lottery winnings or qualified lump-sum income (as defined in subparagraph (J) of such section 1902(e)(14), as added by paragraph (1)(B)(i) of this subsection).

(b) REPEAL OF RETROACTIVE ELIGIBILITY.—

(1) IN GENERAL.—

(A) STATE PLAN REQUIREMENTS.—Section 1902(a)(34) of the Social Security Act (42 U.S.C. 1396a(a)(34)) is amended by striking ''in or after the third month before the month in which he made application'' and inserting ''in or after the month in which the individual made application''.

(B) DEFINITION OF MEDICAL ASSISTANCE.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by striking ''in or after the third month before the month in which the recipient makes application for assistance'' and inserting ''in or after the month in which the recipient makes application for assistance''.

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

(c) UPDATING ALLOWABLE HOME EQUITY LIMITS IN MEDICAID.—

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

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

(B) by striking subparagraph (B);

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

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

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—The amendments made by paragraph (1) shall apply with respect to eligibility determinations made after the date that

is 180 days after the date of the enactment of this section.

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

SEC. 115. SAFETY NET FUNDING FOR NON-EXPANSION STATES.

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

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

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

and by uninsured patients) to individuals who either are eligible for medical assistance under the State plan (or under a waiver of such plan) or have no health insurance or health plan coverage for such services.

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

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

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

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

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

lation for whom poverty status is determined based on the 2015 American Community Survey 1–Year Estimates, as published by the Bureau of the Census), to

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

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

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

(a) IN GENERAL.—Section 1902(e)(14) of the Social Security Act (42 U.S.C. 1396a(e)(14)) (relating to modified adjusted gross income), as amended by section 114(a)(1), is further amended by adding at the end the following:

''(K) FREQUENCY OF ELIGIBILITY REDETERMINATIONS.—Beginning on October 1, 2017, and notwithstanding subparagraph (H), in the case of an individual whose eligibility for medical assistance under the State plan under

this title (or a waiver of such plan) is determined based on the application of modified adjusted gross income under subparagraph (A) and who is so eligible on the basis of clause (i)(VIII) or clause (ii)(XX) of subsection (a)(10)(A), a State shall redetermine such individual's eligibility for such medical assistance no less frequently than once every 6 months.''.

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

SEC. 117. PERMITTING STATES TO APPLY A WORK REQUIREMENT FOR NONDISABLED, NONELDERLY, NONPREGNANT ADULTS UNDER MEDICAID.

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

''(oo) WORK REQUIREMENT OPTION FOR NONDISABLED, NONELDERLY, NONPREGNANT ADULTS.—

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

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

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

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

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

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

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

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

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

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

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

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

Subtitle C—Per Capita Allotment for Medical Assistance

SEC. 121. PER CAPITA ALLOTMENT FOR MEDICAL ASSISTANCE.

Title XIX of the Social Security Act is amended—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(A) for fiscal year 2016, the product of—

''(i) the amount of the medical assistance expenditures (as defined in paragraph (2)) for the State and fiscal year, reduced by the amount of any excluded expenditures (as defined in paragraph (3)) for the State and fiscal year otherwise included in such medical assistance expenditures; and

''(ii) the 1903A FY16 population percentage (as defined in paragraph (4)) for the State; or

''(B) for fiscal year 2019 or a subsequent fiscal year, the amount of the medical assistance expenditures (as defined in paragraph (2)) for the State and fiscal year that is attributable to 1903A enrollees, reduced by the amount of any excluded expenditures (as defined in paragraph (3)) for the State and fiscal year otherwise included in such medical assistance expenditures and includes non-DSH supplemental payments (as defined in subsection (d)(4)(A)(ii)) and payments described in sub-

section (d)(4)(A)(iii) but shall not be construed as including any expenditures attributable to the program under section 1928. In applying subparagraph (B), non-DSH supplemental payments (as defined in subsection (d)(4)(A)(ii)) and payments described in subsection (d)(4)(A)(iii) shall be treated as fully attributable to 1903A enrollees.

''(2) MEDICAL ASSISTANCE EXPENDITURES.—In this section, the term 'medical assistance expenditures' means, for a State and fiscal year, the medical assistance payments as reported by medical service category on the Form CMS-64 quarterly expense report (or successor to such a report form, and including enrollment data and subsequent adjustments to any such report, in this section referred to collectively as a 'CMS-64 report') for which payment is (or may otherwise be) made pursuant to section 1903(a)(1).

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

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

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

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

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

"(c) TARGET TOTAL MEDICAL ASSISTANCE EXPENDITURES.—

"(1) CALCULATION.—In this section, the term 'target total medical assistance expenditures' means, for a State for a fiscal year and subject to paragraph (4), the sum of the products, for each of the

1903A enrollee categories (as defined in subsection (e)(2)), of—

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

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

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

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

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

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

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

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

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

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

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

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

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

''(A) IN GENERAL.—In the case of a State that had a DSH allotment under section 1923(f) for fiscal year 2016 that was more than 6 times the national average of such allotments for all the States for such fiscal year and that requires political subdivisions within the State to contribute funds towards medical assistance or other expenditures under the State plan under this title (or under a waiver of such plan) for a fiscal year (beginning with fiscal year 2020), the target total medical assistance expenditures for such State and fiscal year shall be decreased by the amount that political subdivisions in the State are required to contribute under the plan (or waiver) without reimbursement from the State for such fiscal year, other than contributions described in subparagraph (B).

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

''(i) Contributions required by a State from a political subdivision that, as of the

first day of the calendar year in which the fiscal year involved begins—

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

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

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

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

"(1) CALCULATION OF BASE AMOUNTS FOR FISCAL YEAR 2016.—For each State the Secretary shall calculate (and provide notice to the State not later than April 1, 2018, of) the following:

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

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

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

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

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

''(2) FISCAL YEAR 2019 AVERAGE PER CAPITA AMOUNT BASED ON INFLATING THE FISCAL YEAR 2016 AMOUNT TO FISCAL YEAR 2019 BY CPI-MEDICAL.—The Secretary shall calculate a fiscal year 2019 average per capita amount for each State equal to—

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

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

''(3) AGGREGATE AND AVERAGE EXPENDITURES PER CAPITA FOR FISCAL YEAR 2019.—The Secretary shall calculate for each State the following:

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

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

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

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

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

"(I) is not made under section 1923;

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

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

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

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

similar expenditure (as defined by the Secretary).

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

''(C) For fiscal year 2016, the State's non-DSH supplemental and pool payment percentage is equal to the ratio (expressed as a percentage) of—

''(i) the total amount of non-DSH supplemental expenditures (as defined in subparagraph (A)(ii)) and payments described in subparagraph (A)(iii) for the State for fiscal year 2016; to

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

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

''(i) the amount calculated under subparagraph (A) for the State, increased by the non-DSH supplemental and pool pay-

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

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

"(5) PROVISIONAL FY19 PER CAPITA TARGET AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—Subject to subsection (f)(2), the Secretary shall calculate for each State a provisional FY19 per capita target amount for each 1903A enrollee category equal to the average medical assistance expenditures per capita for the State for fiscal year 2019 (as calculated under paragraph (4)(D)) for such enrollee category multiplied by the ratio of—

"(A) the product of—

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

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

"(B) the amount of the adjusted total medical assistance expenditures for the State

for fiscal year 2019, as calculated under paragraph (3)(A).

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

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

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

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

''(C) BREAST AND CERVICAL CANCER SERVICES ELIGIBLE INDIVIDUAL.—An individual who is entitled to medical assistance under this title only pursuant to section 1902(a)(10)(A)(ii)(XVIII).

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

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

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

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

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

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

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

''(B) BLIND AND DISABLED.—A category of 1903A enrollees (not described in the previous subparagraph) who are eligible for medical assistance under this title on the basis of being blind or disabled.

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

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

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

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

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

''(f) SPECIAL PAYMENT RULES.—

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

shall supersede any other payment limitations or provisions (including limitations based on a per capita limitation) otherwise applicable under such a waiver.

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

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

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

for which such expenditure and enrollee data were not satisfactorily submitted were a single 1903A enrollee category; and

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

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

"(h) REQUIRED REPORTING AND AUDITING OF CMS–64 DATA; TRANSITIONAL INCREASE IN FEDERAL

MATCHING PERCENTAGE FOR CERTAIN ADMINISTRATIVE EXPENSES.—

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

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

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

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

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

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

''(i) FLEXIBLE BLOCK GRANT OPTION FOR STATES.—

''(1) IN GENERAL.—In the case of a State that elects the option of applying this subsection for a 10-fiscal-year period (beginning no earlier than fiscal

year 2020 and, at the State option, for any succeeding 10-fiscal-year period) and that has a plan approved by the Secretary under paragraph (2) to carry out the option for such period—

"(A) the State shall receive, instead of amounts otherwise payable to the State under this title for medical assistance for block grant individuals within the applicable block grant category (as defined in paragraph (6)) for the State during the period in which the election is in effect, the amount specified in paragraph (4);

"(B) the previous provisions of this section shall be applied as if—

"(i) block grant individuals within the applicable block grant category for the State and period were not section 1903A enrollees for each 10-fiscal year period for which the State elects to apply this subsection; and

"(ii) if such option is not extended at the end of a 10-fiscal-year-period, the per capita limitations under such previous provisions shall again apply after such period and such limitations shall be applied as if

the election under this subsection had never taken place;

"(C) the payment under this subsection may only be used consistent with the State plan under paragraph (2) for block grant health care assistance (as defined in paragraph (7)); and

"(D) with respect to block grant individuals within the applicable block grant category for the State for which block grant health care assistance is made available under this subsection, such assistance shall be instead of medical assistance otherwise provided to the individual under this title.

"(2) STATE PLAN FOR ADMINISTERING BLOCK GRANT OPTION.—

"(A) IN GENERAL.—No payment shall be made under this subsection to a State pursuant to an election for a 10-fiscal-year period under paragraph (1) unless the State has a plan, approved under subparagraph (B), for such period that specifies—

"(i) the applicable block grant category with respect to which the State will apply the option under this subsection for such period;

"(ii) the conditions for eligibility of block grant individuals within such applicable block grant category for block grant health care assistance under the option, which shall be instead of other conditions for eligibility under this title, except that in the case of a State that has elected the applicable block grant category described in—

"(I) subparagraph (A) of paragraph (6), the plan must provide for eligibility for pregnant women and children required to be provided medical assistance under subsections (a)(10)(A)(i) and (e)(4) of section 1902; or

"(II) subparagraph (B) of paragraph (6), the plan must provide for eligibility for pregnant women required to be provided medical assistance under subsection (a)(10)(A)(i); and

"(iii) the types of items and services, the amount, duration, and scope of such services, the cost-sharing with respect to

such services, and the method for delivery of block grant health care assistance under this subsection, which shall be instead of the such types, amount, duration, and scope, cost-sharing, and methods of delivery for medical assistance otherwise required under this title, except that the plan must provide for assistance for—

"(I) hospital care;

"(II) surgical care and treatment;

"(III) medical care and treatment;

"(IV) obstetrical and prenatal care and treatment;

"(V) prescribed drugs, medicines, and prosthetic devices;

"(VI) other medical supplies and services; and

"(VII) health care for children under 18 years of age.

"(B) REVIEW AND APPROVAL.—A plan described in subparagraph (A) shall be deemed approved by the Secretary unless the Secretary determines, within 30 days after the date of the

Secretary's receipt of the plan, that the plan is incomplete or actuarially unsound and, with respect to such plan and its implementation under this subsection, the requirements of paragraphs (1), (10)(B), (17), and (23) of section 1902(a) shall not apply.

''(3) AMOUNT OF BLOCK GRANT FUNDS.—

''(A) FOR INITIAL FISCAL YEAR.—The block grant amount under this paragraph for a State for the initial fiscal year in the first 10-fiscal-year period is equal to the sum of the products (for each applicable block grant category for such State and period) of—

''(i) the target per capita medical assistance expenditures for such State for such fiscal year (under subsection (c)(2));

''(ii) the number of 1903A enrollees for such category and State for fiscal year 2019, as determined under subsection (e)(4); and

''(iii) the Federal average medical assistance matching percentage (as defined in subsection (a)(4)) for the State for fiscal year 2019.

"(B) FOR ANY SUBSEQUENT FISCAL YEAR.—The block grant amount under this paragraph for a State for each succeeding fiscal year (in any 10-fiscal-year period) is equal to the block grant amount under subparagraph (A) (or this subparagraph) for the State for the previous fiscal year increased by the annual increase in the consumer price index for all urban consumers (all items; U.S. city average) for the fiscal year involved.

"(C) AVAILABILITY OF ROLLOVER FUNDS.—The block grant amount under this paragraph for a State for a fiscal year shall remain available to the State for expenditures under this subsection for the succeeding fiscal year but only if an election is in effect under this subsection for the State in such succeeding fiscal year.

"(4) FEDERAL PAYMENT AND STATE RESPONSIBILITY.—The Secretary shall pay to each State with an election in effect under this subsection for a fiscal year, from its block grant amount under paragraph (3) available for such fiscal year, an amount for each quarter of such fiscal year equal to the enhanced FMAP described in the first sentence of sec-

tion 2105(b) of the total amount expended under the State plan under this subsection during such quarter, and the State is responsible for the balance of funds to carry out such plan.

''(5) BLOCK GRANT INDIVIDUAL DEFINED.—In this subsection, the term 'block grant individual' means, with respect to a State for a 10-fiscal-year period, an individual who is not disabled (as defined for purposes of the State plan) and who is within an applicable block grant category for the State and such period.

''(6) APPLICABLE BLOCK GRANT CATEGORY DEFINED.—In this subsection, the term 'applicable block grant category' means with respect to a State for a 10-fiscal-year period, either of the following as specified by the State for such period in its plan under paragraph (2)(A)(i):

''(A) 2 ENROLLEE CATEGORIES.—Both of the following 1903A enrollee categories:

''(i) CHILDREN.—The 1903A enrollee category specified in subparagraph (C) of subsection (e)(2).

''(ii) OTHER NONELDERLY, NON-DISABLED, NON-EXPANSION ADULTS.—The

1903A enrollee category specified in subparagraph (E) of such subsection.

''(B) OTHER NONELDERLY, NONDISABLED, NON-EXPANSION ADULTS.—Only the 1903A enrollee category specified in subparagraph (E) of subsection (e)(2).

''(7) BLOCK GRANT HEALTH CARE ASSISTANCE.—In this subsection, the term 'block grant health care assistance' means assistance for health-care-related items and medical services for block grant individuals within the applicable block grant category for the State and 10-fiscal-year period involved who are low-income individuals (as defined by the State).

''(8) AUDITING.—As a condition of receiving funds under this subsection, a State shall contract with an independent entity to conduct audits of its expenditures made with respect to activities funded under this subsection for each fiscal year for which the State elects to apply this subsection to ensure that such funds are used consistent with this subsection and shall make such audits available to the Secretary upon the request of the Secretary.''.

Subtitle D—Patient Relief and Health Insurance Market Stability

SEC. 131. REPEAL OF COST-SHARING SUBSIDY.

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

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

SEC. 132. PATIENT AND STATE STABILITY FUND.

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

"TITLE XXII—PATIENT AND STATE STABILITY FUND

"SEC. 2201. ESTABLISHMENT OF PROGRAM.

''There is hereby established the 'Patient and State Stability Fund' to be administered by the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as the 'Administrator'), to provide funding, in accordance with this title, to the 50 States and the District of Columbia (each referred to in this section as a 'State') during the period, subject to section 2204(c), beginning on January 1, 2018, and ending on

December 31, 2026, for the purposes described in section 2202.

"SEC. 2202. USE OF FUNDS.

"(a) IN GENERAL.—Subject to subsections (b) and (c), a State may use the funds allocated to the State under this title for any of the following purposes:

"(1) Helping, through the provision of financial assistance, high-risk individuals who do not have access to health insurance coverage offered through an employer enroll in health insurance coverage in the individual market in the State, as such market is defined by the State (whether through the establishment of a new mechanism or maintenance of an existing mechanism for such purpose).

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

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

costs of health insurance coverage due to the low density population of the State in which they reside.

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

''(5) Promoting access to preventive services; dental care services (whether preventive or medically necessary); vision care services (whether preventive or medically necessary); or any combination of such services.

''(6) Maternity coverage and newborn care.

''(7) Prevention, treatment, or recovery support services for individuals with mental or substance use disorders, focused on either or both of the following:

''(A) Direct inpatient or outpatient clinical care for treatment of addiction and mental illness.

''(B) Early identification and intervention for children and young adults with serious mental illness.

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

''(9) Providing assistance to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled in health insurance coverage in the State.

''(b) REQUIRED USE OF INCREASE IN ALLOTMENT.—A State shall use the additional allocation provided to the State from the funds appropriated under the second sentence of section 2204(a) for each year only for the purposes described in paragraphs (6) and (7) of subsection (a).

''(c) REQUIRED USE OF ADDITIONAL INCREASE TO CERTAIN WAIVER STATES TO PROVIDE FINANCIAL HARDSHIP ASSISTANCE.—A State shall use the additional allocation provided to the State from the funds appropriated under the last sentence of section 2204(a) only in accordance with such last sentence.

''SEC. 2203. STATE ELIGIBILITY AND APPROVAL; DEFAULT SAFEGUARD.

''(a) ENCOURAGING STATE OPTIONS FOR ALLOCATIONS.—

''(1) IN GENERAL.—To be eligible for an allocation of funds under this title for a year during the period described in section 2201 for use for one or more purposes described in section 2202, a State shall submit to the Administrator an application at

such time (but, in the case of allocations for 2018, not later than 45 days after the date of the enactment of this title and, in the case of allocations for a subsequent year, not later than March 31 of the previous year) and in such form and manner as specified by the Administrator and containing—

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

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

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

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

''(3) ONE-TIME APPLICATION.—If an application of a State is approved for a year, with respect to a purpose described in section 2202, such applica-

tion shall be treated as approved, with respect to such purpose, for each subsequent year through 2026.

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

''(b) DEFAULT FEDERAL SAFEGUARD.—

''(1) IN GENERAL.—

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

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

"(2) REQUIRED USE FOR MARKET STABILIZATION PAYMENTS TO ISSUERS.—Subject to section 2204(a), an allocation for a State made pursuant to paragraph (1) for a year shall be used to carry out the purpose described in section 2202(2) in such State by providing payments to appropriate entities described in such section with respect to claims that exceed $50,000 (or, with respect to allocations made under this title for 2020 or a subsequent year during the period specified in section 2201, such dollar amount specified by the Administrator), but do not exceed $350,000 (or, with respect to allocations made under this title for 2020 or a subsequent year during such period, such dollar amount specified by the Administrator), in an amount equal to 75 per-

cent (or, with respect to allocations made under this title for 2020 or a subsequent year during such period, such percentage specified by the Administrator) of the amount of such claims.

"SEC. 2204. ALLOCATIONS.

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

"(1) for 2018, $15,000,000,000;

"(2) for 2019, $15,000,000,000;

"(3) for 2020, $10,000,000,000;

"(4) for 2021, $10,000,000,000;

"(5) for 2022, $10,000,000,000;

"(6) for 2023, $10,000,000,000;

"(7) for 2024, $10,000,000,000;

"(8) for 2025, $10,000,000,000; and

"(9) for 2026, $10,000,000,000.

The amount otherwise appropriated under the previous sentence for 2020 shall be increased by $15,000,000,000, to be used and available under subsection (d) only for the purposes described in paragraphs (6) and (7) of section 2202(a). The amount otherwise appropriated under this subsection shall be increased by $8,000,000,000 for the period beginning with 2018 and ending with 2023, to be

allocated to States with a waiver in effect under section 2701(b) of the Public Health Service Act with respect to the purpose described in paragraph (1)(C) of such section, in accordance with an allocation methodology specified by the Secretary that takes into account the relative allocation of other amounts appropriated under this subsection among such States, and to be used by (and made available under subsection (d), for any year during such period that such waiver is in effect, to) such States for the purpose of providing assistance to reduce premiums or other out-of-pocket costs of individuals who are subject to an increase in the monthly premium rate for health insurance coverage as a result of such waiver.

''(b) ALLOCATIONS.—

''(1) PAYMENT.—

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

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

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

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

''(2) ALLOCATION AMOUNT DETERMINATIONS.—

''(A) FOR 2018 AND 2019.—

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

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

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

''(ii) RELATIVE INCURRED CLAIMS AMOUNT.—For purposes of clause (i), the relative incurred claims amount described

in this clause for a State for 2018 and 2019 is the product of—

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

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

"(iii) RELATIVE STATE INCURRED CLAIMS PROPORTION.—The relative State incurred claims proportion described in this clause for a State and year is the amount equal to the ratio of—

"(I) the adjusted incurred claims by the State, as reported through the medical loss ratio annual reporting under section 2718 of the Public Health Service Act for the third previous year; to

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

"(iv) RELATIVE UNINSURED AND ISSUER PARTICIPATION AMOUNT.—For purposes of clause (i), the relative unin-

sured and issuer participation amount described in this clause for a State for 2018 and 2019 is the product of—

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

"(II) the relative State uninsured and issuer participation proportion described in clause (v) for such State and year.

"(v) RELATIVE STATE UNINSURED AND ISSUER PARTICIPATION PROPORTION.—The relative State uninsured and issuer participation proportion described in this clause for a State and year is—

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

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

"(aa) the number of individuals residing in such State who for the third preceding year were not enrolled in a health plan or

otherwise did not have health insurance coverage (including through a Federal or State health program) and whose income is below 100 percent of the poverty line applicable to a family of the size involved; to

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

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

''(I) The ratio described in subclause (II) of clause (v) that would be determined for such State by substituting '2015' for each reference in such subclause to 'the third preceding year' and by substituting 'all such States' for the reference in item (bb) of such subclause to 'all States described in clause (vi)' is greater than

the ratio described in such subclause that would be determined for such State by substituting '2013' for each reference in such subclause to 'the third preceding year' and by substituting 'all such States' for the reference in item (bb) of such subclause to 'all States described in clause (vi)'.

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

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

''(i) takes into consideration the adjusted incurred claims of such State, the number of residents of such State who for the previous year were not enrolled in a health plan or otherwise did not have health insurance coverage (including

through a Federal or State health program) and whose income is below 100 percent of the poverty line applicable to a family of the size involved, and the number of health insurance issuers participating in the insurance market in such State for such year;

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

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

''(c) ANNUAL DISTRIBUTION OF PREVIOUS YEAR'S REMAINING FUNDS.— In carrying out subsection (b), the Administrator shall, with respect to a year (beginning with 2020 and ending with 2027), not later than March 31 of such year—

"(1) determine the amount of funds, if any, from the amounts appropriated under subsection (a) for the previous year but not allocated for such previous year; and

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

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

"(B) for States for which allocations were made pursuant to section 2203(b) for such previous year, to be used by the Administrator for such States, to carry out the Federal Invisible Risk Sharing Program in such States under section 2205;

with, respect to a year before 2027, any remaining funds being made available for allocations to States for the subsequent year.

"(d) AVAILABILITY.—Amounts appropriated under subsection (a) for a year and allocated to States in accord-

ance with this section shall remain available for expenditure through December 31, 2027.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''SEC. 2205. FEDERAL INVISIBLE RISK SHARING PROGRAM.

''(a) IN GENERAL.—There is established within the Patient and State Stability Fund a Federal Invisible Risk Sharing Program (in this section referred to as the 'Program'), to be administered by the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as the 'Administrator'), to provide payments to health insurance issuers with respect to claims for eligi-

ble individuals for the purpose of lowering premiums for health insurance coverage offered in the individual market.

''(b) FUNDING.—

''(1) APPROPRIATION.—For the purpose of providing funding for the Program there is appropriated, out of any money in the Treasury not otherwise appropriated, $15,000,000,000 for the period beginning on January 1, 2018, and ending on December 31, 2026.

''(2) USE OF UNALLOCATED FUNDS.—Funds provided under section 2204(c)(2)(B) to carry out this section are in addition to the amount appropriated under paragraph (1).

''(c) OPERATION OF PROGRAM.—

''(1) IN GENERAL.—The Administrator shall establish, after consultation with health care consumers, health insurance issuers, State insurance commissioners, and other stakeholders and after taking into consideration high cost health conditions and other health trends that generate high cost, parameters for the operation of the Program consistent with this section and consistent with the same limitation on payment with respect to health insurance coverage that applies to payment with respect health benefits coverage under section 2105(c)(7).

''(2) DEADLINE FOR INITIAL OPERATION.—Not later than 60 days after the date of the enactment of this title, the Administrator shall establish sufficient parameters to specify how the Program will operate for plan year 2018.

''(3) STATE OPERATION OF PROGRAM.—The Administrator shall establish a process for a State to operate the Program in such State beginning with plan year 2020.

''(d) DETAILS OF PROGRAM.—The parameters for the Program shall include the following:

''(1) ELIGIBLE INDIVIDUALS.—A definition for eligible individuals.

''(2) HEALTH STATUS STATEMENTS.—The development and use of health status statements with respect to such individuals.

''(3) STANDARDS FOR QUALIFICATION.—

''(A) AUTOMATIC QUALIFICATION.—The identification of health conditions that automatically qualify individuals as eligible individuals at the time of application for health insurance coverage.

''(B) VOLUNTARY QUALIFICATION.—A process under which health insurance issuers may voluntarily qualify individuals, who do not

automatically qualify under subparagraph (A), as eligible individuals at the time of application for such coverage.

''(4) PERCENTAGE OF INSURANCE PREMIUMS TO BE APPLIED.—The percentage of the premiums paid, to health insurance issuers for health insurance coverage by eligible individuals, that shall be collected and deposited to the credit (and available for the use) of the Program.

''(5) ATTACHMENT DOLLAR AMOUNT AND PAYMENT PROPORTION.—The dollar amount of claims for eligible individuals after which the Program will provide payments to health insurance issuers and the proportion of such claims above such dollar amount that the Program will pay.''.

SEC. 133. CONTINUOUS HEALTH INSURANCE COVERAGE INCENTIVE.

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

(1) in section 2701(a)(1)(B), by striking ''such rate'' and inserting ''subject to section 2710A, such rate'';

(2) by redesignating the second section 2709 as section 2710; and

(3) by adding at the end the following new section:

"SEC. 2710A. ENCOURAGING CONTINUOUS HEALTH INSURANCE COVERAGE.

"(a) PENALTY APPLIED.—

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

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

premium rate otherwise applicable to such applicable policyholder for such coverage during such month.

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

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

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

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

''(C) in the case of an individual who had been enrolled under dependent coverage under a group health plan or health insurance coverage

by reason of section 2714 and such dependent coverage of such individual ceased because of the age of such individual, is not enrolling during the first open enrollment period following the date on which such coverage so ceased.

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

''(3) ENFORCEMENT PERIOD.—The term 'enforcement period' means—

''(A) with respect to enrollments during a special enrollment period for plan year 2018, the period beginning with the first month that is during such plan year and that begins subsequent to such date of enrollment, and ending with the last month of such plan year; and

''(B) with respect to enrollments for plan year 2019 or a subsequent plan year, the 12-

month period beginning on the first day of the respective plan year.''.

SEC. 134. INCREASING COVERAGE OPTIONS.

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

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

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

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

SEC. 135. CHANGE IN PERMISSIBLE AGE VARIATION IN HEALTH INSURANCE PREMIUM RATES.

Section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)(iii)), as inserted by section 1201(4) of the Patient Protection and Affordable Care Act, is amended by inserting after ''(consistent with section 2707(c))'' the following: ''or, for plan years begin-

ning on or after January 1, 2018, as the Secretary may implement through interim final regulation, 5 to 1 for adults (consistent with section 2707(c)) or such other ratio for adults (consistent with section 2707(c)) as the State involved may provide (or, in the case of a State with a waiver under subsection (b) in effect for such a plan year, the ratio applied for such plan year in accordance with such waiver)''.

SEC. 136. PERMITTING STATES TO WAIVE CERTAIN ACA REQUIREMENTS TO ENCOURAGE FAIR HEALTH INSURANCE PREMIUMS.

(a) IN GENERAL.—Section 2701 of the Public Health Service Act (42 U.S.C. 300gg) is amended by adding at the end the following new subsection:

''(b) PERMISSIBLE STATE WAIVER TO ENCOURAGE FAIR HEALTH INSURANCE PREMIUMS.—

''(1) IN GENERAL.—A State may submit an application to the Secretary for one or more of the following purposes:

''(A) In the case of plan years beginning on or after January 1, 2018, to apply, subject to paragraph (5), under subsection (a)(1)(A)(iii), instead of the ratio specified in such subsection, a higher ratio specified by the State (consistent with section 2707(c)).

"(B) In the case of plan years beginning on or after January 1, 2020, for health insurance coverage offered in the individual or small group market in such State, to apply, subject to paragraph (5), instead of the essential health benefits specified under subsection (b) of section 1302 of the Patient Protection and Affordable Care Act, essential health benefits as specified by the State.

"(C) In the case of a State that has in place a program that carries out the purpose described in paragraph (1) or (2) of section 2202(a) of the Social Security Act or participates in the program established under section 2205 of such Act, for health insurance offered in the individual market in such State, with respect to an individual who is an applicable policyholder of such coverage with respect to an enforcement period (as defined in section 2710A(b)) applicable to enrollments for a plan year beginning with plan year 2019 (or, in the case of enrollments during a special enrollment period, beginning with plan year 2018), to—

"(i) subject to paragraph (5), not apply any increase to the monthly premium

rate that would otherwise apply under section 2710A to such individual for such coverage; and

"(ii) instead, subject to paragraph (5)—

"(I) apply subsection (a)(1) as if health status were included as a factor described in subparagraph (A) of such subsection; and

"(II) not apply section 2705(b).

"(2) DEFAULT APPROVAL.—An application submitted under paragraph (1) is approved unless the Secretary notifies the State submitting the application, not later than 60 days after the date of the submission of such application, that the application has been denied for not being in compliance with any requirement of paragraph (3) and of the reason for such denial.

"(3) REQUIREMENTS.—The requirements of this paragraph, with respect to an application submitted under paragraph (1), are the following:

"(A) The application is submitted at such time, and in such manner, as the Secretary may require.

''(B) The application specifies how the approval of such application will provide for one or more of the following:

''(i) Reducing average premiums for health insurance coverage in the State.

''(ii) Increasing enrollment in health insurance coverage in the State.

''(iii) Stabilizing the market for health insurance coverage in the State.

''(iv) Stabilizing premiums for individuals with pre-existing conditions.

''(v) Increasing the choice of health plans in the State.

''(C) The application specifies the period for which the waiver is to be effective, consistent with paragraph (4).

''(D) In the case of an application for purposes of paragraph (1)(A), the application specifies the higher ratio to be applied pursuant to such paragraph.

''(E) In the case of an application for purposes of paragraph (1)(B), the application specifies the essential health benefits to be applied pursuant to such paragraph.

''(F) In the case of an application for purposes of paragraph (1)(C), the application demonstrates that the State has in place a program that carries out the purpose described in paragraph (1) or (2) of section 2202(a) of the Social Security Act or participates in the program established under section 2205 of such Act.

''(4) TERM OF WAIVER.—

''(A) IN GENERAL.—No waiver for a State under this subsection may extend over a period of longer than 10 years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request.

''(B) SPECIAL RULE.—A waiver applied for by a State under paragraph (1)(C) may only be effective for a period during which the State—

''(i) has in place a program that carries out the purpose described in para-

graph (1) or (2) of section 2202(a) of the Social Security Act; or

''(ii) participates in the program established under section 2205 of such Act.

''(5) NON-APPLICATION RULES.—

''(A) SPECIFIED NON-APPLICATION PROVISIONS.—In no case may a waiver for purposes of paragraph (1) apply with respect to any of the following provisions:

''(i) Section 1301 of the Patient Protection and Affordable Care Act, to the extent that such section applies to qualified health plans offered through the CO-OP program under section 1322 of such Act or multi-State plans under section 1334 of such Act.

''(ii) Sections 1312(d)(3)(D), 1331, 1332, 1333, and 1334 of such Act.

''(B) HOLD HARMLESS.—Any standard or requirement adopted by a State pursuant to the terms of a waiver approved under this subsection shall be deemed to comply with section 1252 of the Patient Protection and Affordable Care Act and subsection (a) of section 1324 of such Act, insofar as such standard or require-

ment relates to a Federal or State law described in subsection (b)(2) of such section (relating to rating).''.

(b) APPLICATION TO ESSENTIAL HEALTH BENEFITS.—Section 1302(a)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(a)(1)) is amended by inserting ''(or, in the case of health insurance coverage offered in the individual or small group market in a State for which there is an applicable waiver in effect under section 2701(b) of the Public Health Service Act for a plan year, the essential health benefits applicable under such waiver)'' after ''subsection (b)''.

SEC. 137. CONSTRUCTIONS.

(a) NO GENDER RATING.—Nothing in this Act shall be construed as permitting health insurance issuers to discriminate in rates for health insurance coverage by gender.

(b) NO LIMITING ACCESS TO COVERAGE FOR INDIVIDUALS WITH PREEXISTING CONDITIONS.—Nothing in this Act shall be construed as permitting health insurance issuers to limit access to health coverage for individuals with preexisting conditions.

Subtitle E—Implementation Funding

SEC. 141. AMERICAN HEALTH CARE IMPLEMENTATION FUND.

(a) IN GENERAL.—There is hereby established an American Health Care Implementation Fund (referred to in this section as the ''Fund'') within the Department of Health and Human Services to carry out sections 121, 132, 202, and 214 (including the amendments made by such sections).

(b) FUNDING.—There is appropriated to the Fund, out of any funds in the Treasury not otherwise appropriated, $1,000,000,000 for Federal administrative expenses to carry out the sections described in subsection (a) (including the amendments made by such sections).

TITLE II—COMMITTEE ON WAYS AND MEANS

Subtitle A—Repeal and Replace of Health-Related Tax Policy

SEC. 201. RECAPTURE EXCESS ADVANCE PAYMENTS OF PREMIUM TAX CREDITS.

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

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

SEC. 202. ADDITIONAL MODIFICATIONS TO PREMIUM TAX CREDIT.

(a) MODIFICATION OF DEFINITION OF QUALIFIED HEALTH PLAN.—

(1) IN GENERAL.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986 is amended—

(A) by inserting ''(determined without regard to subparagraphs (A), (C)(ii), and (C)(iv) of paragraph (1) thereof and without regard to whether the plan is offered on an Exchange)'' after ''1301(a) of the Patient Protection and Affordable Care Act'', and

(B) by striking ''shall not include'' and all that follows and inserting ''shall not include any health plan that—

''(i) is a grandfathered health plan or a grandmothered health plan, or

''(ii) includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with

respect to a pregnancy that is the result of an act of rape or incest).''.

(2) DEFINITION OF GRANDMOTHERED HEALTH PLAN.—Section 36B(c)(3) of such Code is amended by adding at the end the following new subparagraph:

''(C) GRANDMOTHERED HEALTH PLAN.—

''(i) IN GENERAL.—The term 'grandmothered health plan' means health insurance coverage which is offered in the individual health insurance market as of October 1, 2013, and is permitted to be offered in such market after January 1, 2014, as a result of CCIIO guidance.

''(ii) CCIIO GUIDANCE DEFINED.—The term 'CCIIO guidance' means the letter issued by the Centers for Medicare & Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the individual health insurance market, as subsequently extended and modified (including by a communication entitled 'Insurance Standards Bulletin Series—INFORMATION—Ex-

tension of Transitional Policy through Calendar Year 2017' issued on February 29, 2016, by the Director of the Center for Consumer Information & Insurance Oversight of such Centers).

"(iii) INDIVIDUAL HEALTH INSURANCE MARKET.—The term 'individual health insurance market' means the market for health insurance coverage (as defined in section 9832(b)) offered to individuals other than in connection with a group health plan (within the meaning of section 5000(b)(1)).".

(3) CONFORMING AMENDMENT RELATED TO ABORTION COVERAGE.—Section 36B(c)(3) of such Code, as amended by paragraph (2), is amended by adding at the end the following new subparagraph:

"(D) CERTAIN RULES RELATED TO ABORTION.—

"(i) OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.—Nothing in subparagraph (A) shall be construed as prohibiting any individual from purchasing separate coverage for abortions described in such subparagraph, or a health plan that in-

cludes such abortions, so long as no credit is allowed under this section with respect to the premiums for such coverage or plan.

''(ii) OPTION TO OFFER COVERAGE OR PLAN.—Nothing in subparagraph (A) shall restrict any health insurance issuer offering a health plan from offering separate coverage for abortions described in such subparagraph, or a plan that includes such abortions, so long as premiums for such separate coverage or plan are not paid for with any amount attributable to the credit allowed under this section (or the amount of any advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

''(iii) OTHER TREATMENTS.—The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion shall not be treated as an abortion for purposes of subparagraph (A).''.

(4) CONFORMING AMENDMENTS RELATED TO OFF-EXCHANGE COVERAGE.—

(A) ADVANCE PAYMENT NOT APPLICABLE.—Section 1412 of the Patient Protection and Affordable Care Act is amended by adding at the end the following new subsection:

''(f) EXCLUSION OF OFF-EXCHANGE COVERAGE.—Advance payments under this section, and advance determinations under section 1411, with respect to any credit allowed under section 36B shall not be made with respect to any health plan which is not enrolled in through an Exchange.''.

(B) REPORTING.—Section 6055(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(3) INFORMATION RELATING TO OFF-EXCHANGE PREMIUM CREDIT ELIGIBLE COVERAGE.—If minimum essential coverage provided to an individual under subsection (a) consists of a qualified health plan (as defined in section 36B(c)(3)) which is not enrolled in through an Exchange established under title I of the Patient Protection and Affordable Care Act, a return described in this subsection shall include—

''(A) a statement that such plan is a qualified health plan (as defined in section 36B(c)(3)),

''(B) the premiums paid with respect to such coverage,

''(C) the months during which such coverage is provided to the individual,

''(D) the adjusted monthly premium for the applicable second lowest cost silver plan (as defined in section 36B(b)(3)) for each such month with respect to such individual, and

''(E) such other information as the Secretary may prescribe.''.

(C) OTHER CONFORMING AMENDMENTS.—

(i) Section 36B(b)(2)(A) of such Code is amended by striking ''and which were enrolled'' and all that follows and inserting '', or''.

(ii) Section 36B(b)(3)(B)(i) of such Code is amended by striking ''the same Exchange'' and all that follows and inserting ''the Exchange through which such taxpayer is permitted to obtain coverage, and''.

(iii) Section 36B(c)(2)(A)(i) of such Code is amended by striking ''that was enrolled in through an Exchange established

by the State under section 1311 of the Patient Protection and Affordable Care Act''.

(b) MODIFICATION OF APPLICABLE PERCENTAGE.—Section 36B(b)(3)(A) of such Code is amended to read as follows:

''(A) APPLICABLE PERCENTAGE.—

''(i) IN GENERAL.—The applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial percentage to the final percentage specified in such table for such income tier with respect to a taxpayer of the age involved:

''In the case of household income (expressed as a percent of the poverty line) within the following income tier:	Up to Age 29		Age 30-39		Age 40-49		Age 50-59		Over Age 59	
	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %
Up to 133%	2	2	2	2	2	2	2	2	2	2
133%-150%	3	4	3	4	3	4	3	4	3	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%-400%	4.3	4.3	5.9	5.9	8.35	8.35	10.5	10.5	11.5	11.5

''(ii) AGE DETERMINATIONS.—

''(I) IN GENERAL.—For purposes of clause (i), the age of the taxpayer

taken into account under clause (i) with respect to any taxable year is the age attained by such taxpayer before the close of such taxable year.

''(II) JOINT RETURNS.—In the case of a joint return, the age of the older spouse shall be taken into account under clause (i).

''(iii) INDEXING.—In the case of any taxable year beginning in calendar year 2019, the initial and final percentages contained in clause (i) shall be adjusted to reflect—

''(I) the excess (if any) of the rate of premium growth for the period beginning with calendar year 2013 and ending with calendar year 2018, over the rate of income growth for such period, and

''(II) in addition to any adjustment under subclause (I), the excess (if any) of the rate of premium growth for calendar year 2018, over the rate of growth in the consumer price index for calendar year 2018.

''(iv) FAILSAFE.—Clause (iii)(II) shall apply only if the aggregate amount of premium tax credits under this section and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act for calendar year 2018 exceeds an amount equal to 0.504 percent of the gross domestic product for such calendar year.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to taxable years beginning after December 31, 2017.

(2) ADVANCE PAYMENT NOT APPLICABLE TO OFF-EXCHANGE COVERAGE.—The amendment made by subsection (a)(4)(A) shall take effect on January 1, 2018.

(3) REPORTING.—The amendment made by subsection (a)(4)(B) shall apply to coverage provided for months beginning after December 31, 2017.

(4) MODIFICATION OF APPLICABLE PERCENTAGE.—The amendment made by subsection (b) shall apply to taxable years beginning after December 31, 2018.

SEC. 203. SMALL BUSINESS TAX CREDIT.

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

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

(b) DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT FOR PLAN WHICH INCLUDES COVERAGE FOR ABORTION.—Subsection (h) of section 45R of the Internal Revenue Code of 1986 is amended—

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

''(1) IN GENERAL.—Any term''; and

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

''(2) EXCLUSION OF HEALTH PLANS INCLUDING COVERAGE FOR ABORTION.—

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

"(B) CERTAIN RULES RELATED TO ABORTION.—

"(i) OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.—Nothing in subparagraph (A) shall be construed as prohibiting any employer from purchasing for its employees separate coverage for abortions described in such subparagraph, or a health plan that includes such abortions, so long as no credit is allowed under this section with respect to the employer contributions for such coverage or plan.

"(ii) OPTION TO OFFER COVERAGE OR PLAN.—Nothing in subparagraph (A) shall restrict any health insurance issuer offering a health plan from offering separate coverage for abortions described in such subparagraph, or a plan that includes such abortions, so long as such separate coverage or plan is not paid for with any employer contribution eligible for the credit allowed under this section.

"(iii) OTHER TREATMENTS.—The treatment of any infection, injury, disease, or disorder that has been caused by or ex-

acerbated by the performance of an abortion shall not be treated as an abortion for purposes of subparagraph (A).''.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2019.

(2) DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT FOR PLAN WHICH INCLUDES COVERAGE FOR ABORTION.—The amendments made by subsection (b) shall apply to taxable years beginning after December 31, 2017.

SEC. 204. INDIVIDUAL MANDATE.

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

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

(2) in paragraph (3)—

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

(B) by striking subparagraph (D).

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

SEC. 205. EMPLOYER MANDATE.

(a) IN GENERAL.—

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

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

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

SEC. 206. REPEAL OF THE TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS.

Section 4980I of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(h) SHALL NOT APPLY.—No tax shall be imposed under this section with respect to any taxable period beginning after December 31, 2019, and before January 1, 2026.''.

SEC. 207. REPEAL OF TAX ON OVER-THE-COUNTER MEDICATIONS.

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

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

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

(d) Effective Dates.—

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

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

SEC. 208. REPEAL OF INCREASE OF TAX ON HEALTH SAVINGS ACCOUNTS.

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

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

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

SEC. 209. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO FLEXIBLE SPENDING ACCOUNTS.

(a) In General.—Section 125 of the Internal Revenue Code of 1986 is amended by striking subsection (i).

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

SEC. 210. REPEAL OF MEDICAL DEVICE EXCISE TAX.

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

''(d) Applicability.—The tax imposed under subsection (a) shall not apply to sales after December 31, 2016.''.

SEC. 211. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.

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

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

SEC. 212. REDUCTION OF INCOME THRESHOLD FOR DETERMINING MEDICAL CARE DEDUCTION.

(a) IN GENERAL.—Subsection (a) of section 213 of the Internal Revenue Code of 1986 is amended by striking ''10 percent'' and inserting ''5.8 percent''.

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

SEC. 213. REPEAL OF MEDICARE TAX INCREASE.

(a) IN GENERAL.—Subsection (b) of section 3101 of the Internal Revenue Code of 1986 is amended to read as follows:

''(b) HOSPITAL INSURANCE.—In addition to the tax imposed by the preceding subsection, there is hereby im-

posed on the income of every individual a tax equal to 1.45 percent of the wages (as defined in section 3121(a)) received by such individual with respect to employment (as defined in section 3121(b)).''.

(b) SECA.—Subsection (b) of section 1401 of the Internal Revenue Code of 1986 is amended to read as follows:

''(b) HOSPITAL INSURANCE.—In addition to the tax imposed by the preceding subsection, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to 2.9 percent of the amount of the self-employment income for such taxable year.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received after, and taxable years beginning after, December 31, 2022.

SEC. 214. REFUNDABLE TAX CREDIT FOR HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Section 36B of the Internal Revenue Code of 1986 is amended to read as follows:

''SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

''(a) ALLOWANCE OF PREMIUM TAX CREDIT.—In the case of an individual, there shall be allowed as a credit

against the tax imposed by this subtitle for the taxable year the sum of the monthly credit amounts with respect to such taxpayer for calendar months during such taxable year which are eligible coverage months appropriately taken into account under subsection (b)(2) with respect to the taxpayer or any qualifying family member of the taxpayer.

''(b) MONTHLY CREDIT AMOUNTS.—

''(1) IN GENERAL.—The monthly credit amount with respect to any taxpayer for any calendar month is the lesser of—

''(A) the sum of the monthly limitation amounts determined under subsection (c) with respect to the taxpayer and the taxpayer's qualifying family members for such month, or

''(B) the amount paid for a qualified health plan for the taxpayer and the taxpayer's qualifying family members for such month.

''(2) ELIGIBLE COVERAGE MONTH REQUIREMENT.—No amount shall be taken into account under subparagraph (A) or (B) of paragraph (1) with respect to any individual for any month unless such month is an eligible coverage month with respect to such individual.

''(c) MONTHLY LIMITATION AMOUNTS.—

"(1) IN GENERAL.—The monthly limitation amount with respect to any individual for any eligible coverage month during any taxable year is 1/12 of—

"(A) $2,000 in the case of an individual who has not attained age 30 as of the beginning of such taxable year,

"(B) $2,500 in the case of an individual who has attained age 30 but who has not attained age 40 as of such time,

"(C) $3,000 in the case of an individual who has attained age 40 but who has not attained age 50 as of such time,

"(D) $3,500 in the case of an individual who has attained age 50 but who has not attained age 60 as of such time, and

"(E) $4,000 in the case of an individual who has attained age 60 as of such time.

"(2) LIMITATION BASED ON MODIFIED ADJUSTED GROSS INCOME.—The credit allowed under subsection (a) with respect to any taxpayer for any taxable year shall be reduced (but not below zero) by 10 percent of the excess (if any) of—

"(A) the taxpayer's modified adjusted gross income (as defined in section

36B(d)(2)(B), as in effect for taxable years beginning before January 1, 2020) for such taxable year, over

"(B) $75,000 (twice such amount in the case of a joint return).

"(3) OTHER LIMITATIONS.—

"(A) AGGREGATE DOLLAR LIMITATION.—The sum of the monthly limitation amounts taken into account under this section with respect to any taxpayer for any taxable year shall not exceed $14,000.

"(B) MAXIMUM NUMBER OF INDIVIDUALS TAKEN INTO ACCOUNT.—With respect to any taxpayer for any month, monthly limitation amounts shall be taken into account under this section only with respect to the 5 oldest individuals with respect to whom monthly limitation amounts could (without regard to this subparagraph) otherwise be so taken into account.

"(d) ELIGIBLE COVERAGE MONTH.—For purposes of this section, the term 'eligible coverage month' means, with respect to any individual, any month if, as of the first day of such month, the individual meets the following requirements:

''(1) The individual is covered by a health insurance coverage which is certified by the State in which such insurance is offered as coverage that meets the requirements for qualified health plans under subsection (f).

''(2) The individual is not eligible for—

''(A) coverage under a group health plan (within the meaning of section 5000(b)(1)) other than coverage under a plan substantially all of the coverage of which is of excepted benefits described in section 9832(c), or

''(B) coverage described in section 5000A(f)(1)(A).

''(3) The individual is either—

''(A) a citizen or national of the United States, or

''(B) a qualified alien (within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641)).

''(4) The individual is not incarcerated, other than incarceration pending the disposition of charges.

''(e) QUALIFYING FAMILY MEMBER.—For purposes of this section, the term 'qualifying family member' means—

''(1) in the case of a joint return, the taxpayer's spouse,

''(2) any dependent of the taxpayer, and

''(3) with respect to any eligible coverage month, any child (as defined in section 152(f)(1)) of the taxpayer who as of the end of the taxable year has not attained age 27 if such child is covered for such month under a qualified health plan which also covers the taxpayer (in the case of a joint return, either spouse).

''(f) QUALIFIED HEALTH PLAN.—For purposes of this section, the term 'qualified health plan' means any health insurance coverage (as defined in section 9832(b)) if—

''(1) such coverage is offered in the individual health insurance market within a State (within the meaning of section 5000A(f)(1)(C)),

''(2) substantially all of such coverage is not of excepted benefits described in section 9832(c),

''(3) such coverage does not consist of short-term limited duration insurance (within the meaning

of section 2791(b)(5) of the Public Health Service Act),

''(4) such coverage is not a grandfathered health plan (as defined in section 1251 of the Patient Protection and Affordable Care Act) or a grandmothered health plan (as defined in section 36B(c)(3)(C) as in effect for taxable years beginning before January 1, 2020), and

''(5) such coverage does not include coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).

''(g) SPECIAL RULES.—

''(1) MARRIED COUPLES MUST FILE JOINT RETURN.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), if the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, no credit shall be allowed under this section to such taxpayer unless such taxpayer and the taxpayer's spouse file a joint return for such taxable year.

''(B) EXCEPTION FOR CERTAIN TAXPAYERS.—Subparagraph (A) shall not apply to any married taxpayer who—

''(i) is living apart from the taxpayer's spouse at the time the taxpayer files the tax return,

''(ii) is unable to file a joint return because such taxpayer is a victim of domestic abuse or spousal abandonment,

''(iii) certifies on the tax return that such taxpayer meets the requirements of clauses (i) and (ii), and

''(iv) has not met the requirements of clauses (i), (ii), and (iii) for each of the 3 preceding taxable years.

''(2) DENIAL OF CREDIT TO DEPENDENTS.—

''(A) IN GENERAL.—No credit shall be allowed under this section to any individual who is a dependent with respect to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(B) COORDINATION WITH RULE FOR OLDER CHILDREN.—In the case of any individual who is a qualifying family member de-

scribed in subsection (e)(3) with respect to another taxpayer for any month, in determining the amount of any credit allowable to such individual under this section for any taxable year of such individual which includes such month, the monthly limitation amount with respect to such individual for such month shall be zero and no amount paid for any qualified health plan with respect to such individual for such month shall be taken into account.

''(3) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—Amounts described in subsection (b)(1)(B) with respect to any month shall not be taken into account in determining the deduction allowed under section 213 except to the extent that such amounts exceed the amount described in subsection (b)(1)(A) with respect to such month.

''(4) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT.—With respect to any taxable year—

''(A) the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 1412 of the Patient Protection and Affordable

Care Act for months beginning in such taxable year, and

"(B) the tax imposed by section 1 for such taxable year shall be increased by the excess (if any) of—

"(i) the aggregate amount paid on behalf of such taxpayer under such section 1412 for months beginning in such taxable year, over

"(ii) the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a).

"(5) SPECIAL RULES FOR QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—

"(A) IN GENERAL.—If the taxpayer or any qualifying family member of the taxpayer is provided a qualified small employer health reimbursement arrangement for an eligible coverage month, the sum determined under subsection (b)(1)(A) with respect to the taxpayer shall be reduced (but not below zero) by 1/12 of the permitted benefit (as defined in section 9831(d)(3)(C)) under such arrangement for

each such month such arrangement is provided to such taxpayer.

''(B) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this paragraph, the term 'qualified small employer health reimbursement arrangement' has the meaning given such term by section 9831(d)(2).

''(C) COVERAGE FOR LESS THAN ENTIRE YEAR.—In the case of an employee who is provided a qualified small employer health reimbursement arrangement for less than an entire year, subparagraph (A) shall be applied by substituting 'the number of months during the year for which such arrangement was provided' for '12'.

''(6) CERTAIN RULES RELATED TO NON-QUALIFIED HEALTH PLANS.—The rules of section 36B(c)(3)(D), as in effect for taxable years beginning before January 1, 2020, shall apply with respect to subsection (f)(5).

''(7) INFLATION ADJUSTMENT.—

''(A) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2020, each dollar amount in subsection (c)(1),

the $75,000 amount in subsection (c)(2)(B), and the dollar amount in subsection (c)(3)(A), shall be increased by an amount equal to—

"(i) such dollar amount, multiplied by

"(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined—

"(I) by substituting 'calendar year 2019' for 'calendar year 1992' in subparagraph (B) thereof, and

"(II) by substituting for the CPI referred to section 1(f)(3)(A) the amount that such CPI would have been if the annual percentage increase in CPI with respect to each year after 2019 had been one percentage point greater.

"(B) TERMS RELATED TO CPI.—

"(i) ANNUAL PERCENTAGE INCREASE.—For purposes of subparagraph (A)(ii)(II), the term 'annual percentage increase' means the percentage (if any) by which CPI for any year exceeds CPI for the prior year.

''(ii) OTHER TERMS.—Terms used in this paragraph which are also used in section 1(f)(3) shall have the same meanings as when used in such section.

''(C) ROUNDING.—Any increase determined under subparagraph (A) shall be rounded to the nearest multiple of $50.

''(8) RULES RELATED TO STATE CERTIFICATION OF QUALIFIED HEALTH PLANS.—A certification shall not be taken into account under subsection (d)(1) unless such certification is made available to the public and meets such other requirements as the Secretary may provide.

''(9) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be necessary or appropriate to carry out this section and section 1412 of the Patient Protection and Affordable Care Act.''.

(b) ADVANCE PAYMENT OF CREDIT.—Section 1412(f) of the Patient Protection and Affordable Care Act, as added by section 202, is amended to read as follows:

''(f) APPLICATION TO CERTAIN PLANS.—The Secretary and the Secretary of the Treasury shall prescribe such regulations as each respective Secretary may deem

necessary in order to establish and operate the advance payment program established under this section for individuals covered under qualified health plans (whether enrolled in through an Exchange or otherwise) in such a manner that protects taxpayer information (including names, taxpayer identification numbers, and other confidential information), provides robust verification of all information necessary to establish eligibility of taxpayer for advance payments under this section, ensures proper and timely payments to appropriate health providers, and protects program integrity to the maximum extent feasible.''.

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

(d) REPORTING BY EMPLOYERS.—Section 6051(a) of such Code is amended by striking ''and'' at the end of paragraph (14), by striking the period at the end of paragraph (15) and inserting '', and'', and by inserting after paragraph (15) the following new paragraph:

''(16) each month with respect to which the employee is eligible for coverage described in section

36B(d)(2) in connection with employment with the employer.''.

(e) COORDINATION WITH OTHER TAX BENEFITS.—

(1) CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.—Section 35(g) of such Code is amended by adding at the end the following new paragraph:

''(14) COORDINATION WITH HEALTH INSURANCE COVERAGE CREDIT.—

''(A) IN GENERAL.—An eligible coverage month to which the election under paragraph (11) applies shall not be treated as an eligible coverage month (as defined in section 36B(d)) for purposes of section 36B with respect to the taxpayer or any of the taxpayer's qualifying family members (as defined in section 36B(e)).

''(B) COORDINATION WITH ADVANCE PAYMENTS OF HEALTH INSURANCE COVERAGE CREDIT.—In the case of a taxpayer who makes the election under paragraph (11) with respect to any eligible coverage month in a taxable year or on behalf of whom any advance payment is made under section 7527 with respect to any month in such taxable year—

"(i) the tax imposed by this chapter for the taxable year shall be increased by the excess, if any, of—

"(I) the sum of any advance payments made on behalf of the taxpayer under section 7527 and section 1412 of the Patient Protection and Affordable Care Act, over

"(II) the sum of the credits allowed under this section (determined without regard to paragraph (1)) and section 36B (determined without regard to subsection (g)(4)(A) thereof) for such taxable year, and

"(ii) section 36B(g)(4)(B) shall not apply with respect to such taxpayer for such taxable year.".

(2) TRADE OR BUSINESS DEDUCTION.—Section 162(l) of such Code is amended by adding at the end the following new paragraph:

"(6) COORDINATION WITH HEALTH INSURANCE COVERAGE CREDIT.—The deduction otherwise allowable to a taxpayer under paragraph (1) for any taxable year shall be reduced (but not below zero) by the amount of the credit allowable to such taxpayer

under section 36B (determined without regard to subsection (g)(4)(A) thereof) for such taxable year.''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2019, in taxable years ending after such date.

SEC. 215. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAVINGS ACCOUNT INCREASED TO AMOUNT OF DEDUCTIBLE AND OUT-OF-POCKET LIMITATION.

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

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

(c) CONFORMING AMENDMENTS.—Section 223(g)(1) of such Code is amended—

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

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

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

SEC. 216. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CONTRIBUTIONS TO THE SAME HEALTH SAVINGS ACCOUNT.

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

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

''(A) IN GENERAL.—In the case of individuals who are married to each other, if both spouses are eligible individuals and either spouse has family coverage under a high deductible health plan as of the first day of any month—

''(i) the limitation under paragraph (1) shall be applied by not taking into account any other high deductible health plan coverage of either spouse (and if such spouses both have family coverage under separate high deductible health plans, only one such coverage shall be taken into account),

"(ii) such limitation (after application of clause (i)) shall be reduced by the aggregate amount paid to Archer MSAs of such spouses for the taxable year, and

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

"(B) TREATMENT OF ADDITIONAL CONTRIBUTION AMOUNTS.—If both spouses referred to in subparagraph (A) have attained age 55 before the close of the taxable year, the limitation referred to in subparagraph (A)(iii) which is subject to division between the spouses shall include the additional contribution amounts determined under paragraph (3) for both spouses. In any other case, any additional contribution amount determined under paragraph (3) shall not be taken into account under subparagraph (A)(iii) and shall not be subject to division between the spouses.".

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

SEC. 217. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT.

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

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

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

Subtitle B—Repeal of Certain Consumer Taxes

SEC. 221. REPEAL OF TAX ON PRESCRIPTION MEDICATIONS.

Subsection (j) of section 9008 of the Patient Protection and Affordable Care Act is amended to read as follows:

''(j) REPEAL.—This section shall apply to calendar years beginning after December 31, 2010, and ending before January 1, 2017.''.

SEC. 222. REPEAL OF HEALTH INSURANCE TAX.

Subsection (j) of section 9010 of the Patient Protection and Affordable Care Act is amended to read as follows:

''(j) REPEAL.—This section shall apply to calendar years beginning after December 31, 2013, and ending before January 1, 2017.''.

Subtitle C—Repeal of Tanning Tax

SEC. 231. REPEAL OF TANNING TAX.

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

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

Subtitle D—Remuneration From Certain Insurers

SEC. 241. REMUNERATION FROM CERTAIN INSURERS.

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

"(I) TERMINATION.—This paragraph shall not apply to taxable years beginning after December 31, 2016.".

Subtitle E—Repeal of Net Investment Income Tax

SEC. 251. REPEAL OF NET INVESTMENT INCOME TAX.

(a) IN GENERAL.—Subtitle A of the Internal Revenue Code of 1986 is amended by striking chapter 2A.

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

Passed the House of Representatives May 4, 2017.

Attest: KAREN L. HAAS,

Clerk.

Calendar No. 120

115TH CONGRESS
1ST SESSION

H. R. 1628

AN ACT

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

JUNE 8, 2017

Read twice and placed on the calendar