

SECTION BY SECTION SUMMARY
BETTER CARE RECONCILIATION ACT [ERN17500]

Section 101. Elimination of Limitation on Recapture of Excess Advance Payments of Premium Tax Credits

Section 101 would not apply IRC Section 36B(f)(2)(B), relating to limits on the excess amounts to be repaid with respect to the ACA premium tax credits, to taxable years ending after December 31, 2017. In other words, any individual who was overpaid in premium tax credits would have to repay the entire excess amount, regardless of income, beginning in taxable year 2018.

Section 102. Restrictions for the Premium Tax Credit

Section 102 would make changes to the premium credit's eligibility criteria. It would change the income eligibility to up to 350% FPL from 100%-400% FPL, make changes to the eligibility criteria applicable to certain aliens, and prohibit individuals with access to any employer-sponsored coverage from becoming eligible for the credit. The section would replace the plan used to determine the amount of the credit (the second-lowest-cost silver plan with an actuarial value of 70%) with a benchmark plan with an actuarial value of 58% and a premium that is the median premium of all QHPs with an actuarial value of 58% in the local area. The section would allow an individual who is eligible for the tax credit to apply that credit towards the purchase of a catastrophic plan.

The section would exclude from the definition of QHP a plan that provides coverage for abortions (except if necessary to save the life of the mother or if the pregnancy is the result of rape or incest), beginning tax year 2018.

With respect to the formula for calculating required premium contributions, Section 102 would specify age and income-adjusted applicable percentages beginning tax year 2020. The applicable percentages would range from 2% for those in the lowest income band, regardless of age band, to 16.2% for those in the highest income band and the oldest age band. Individuals in the same income band below 150% FPL would contribute the same percentage of income regardless of age. However, within each income band above 150% FPL, older individuals would be required to contribute more than younger individuals. The section would amend the rules regarding interaction of the premium credit with qualified small employer health reimbursement arrangements.

Section 102 would go into effect beginning tax year 2020, unless specified otherwise.

Section 103. Modifications to Small Business Tax Credit

Beginning in tax year 2018, Section 103 would amend IRC Section 45R to indicate that the term "qualified health plan" does not include any health plan that includes coverage for abortions, except abortions necessary to save the life of a mother or abortions for pregnancies that are a result of rape or incest.

Section 103 would provide that the small business health insurance tax credit would not be available beginning tax year 2020.

Section 104. Individual Mandate

Section 104 would modify the annual penalty associated with IRC Section 5000A, eliminating it by reducing the percentage of income to 0% and the flat dollar amount to \$0, retroactively beginning in calendar year (CY) 2016.

Section 105. Employer Mandate

Section 105 would modify the tax penalty associated with IRC Section 4980H, eliminating it by reducing the penalty to \$0 retroactively beginning in CY2016.

Section 106. State Stability and Innovation Program

Section 106 would add two new subsections (h) and (i) to Section 2105 of the Social Security Act (SSA).¹ The new subsection (h)(1) would appropriate \$15 billion for each of CY2018 and CY2019 and \$10 billion for each of CY2020 and CY2021 to the Administrator of the Centers for Medicare & Medicaid Services (CMS). The CMS Administrator would be required to use the monies to fund arrangements with health insurance issuers to “assist in the purchase of health benefits coverage by addressing coverage and access disruption and responding to urgent health care needs within states.” More specifically, the new subsection (h)(5) would provide that appropriated funds must be used for activities described in 2, below. The new subsection (h)(1) would provide that appropriated funds would remain available until expended.

The new subsection (h)(2) would direct the CMS Administrator to issue guidance to health insurance issuers regarding how to submit notice of intent to participate in the program established under new subsection (h) no later than 30 days after enactment. To be eligible to receive funding under the program, issuers would have to submit the notice in a manner specified by the CMS Administrator. The notice would have to certify that the issuer would use the funds in accordance with specified requirements, and provide other information as required by the CMS Administrator.

The new subsection (h)(3) would direct the CMS Administrator to determine a procedure for providing and distributing the funds. This procedure would include reserving 1% of the appropriated funds in each calendar year for providing and distributing funds to issuers in states where the health insurance premiums are at least 75% higher than the national average.

Per new subsection (h)(4), states would not be required to match grants awarded to issuers under new subsection (h)(1).

The new subsection (h)(5) would provide that funds provided to issuers under (h) would be subject to the requirements described in new subsections (i)(1)(D) and (i)(7), which are described in more detail below.

The new subsection (i) would establish a Long-Term State Stability and Innovation Program. The program would make funding available to the 50 states and the District of Columbia from CY2019 through CY2026. Under the program, a state would be required to submit an application to the CMS Administrator to receive federal funding to carry-out specified activities in the state. States would be able to use payments allocated from the program for one or more of the following allowed activities:

1. to establish or maintain a program or mechanism to help high-risk individuals purchase health benefits coverage, including by reducing premiums for such individuals, who have or are projected to have high health care utilization (as measured by cost) and who do not have access to employer-sponsored insurance;
2. to establish or maintain a program to enter into arrangements with health insurance issuers to assist in the purchase of health benefits coverage by stabilizing premiums and promoting market participation and plan choice in the individual market;
3. to provide payments for health care providers for the provision of services specified by the CMS Administrator; and

¹ Title XXI of the Social Security Act (SSA) established the State Children’s Health Insurance Program (CHIP).

4. to provide health insurance coverage by funding assistance to reduce out-of-pocket costs (such as copayments, coinsurance, and deductibles) for individuals with individual health insurance coverage.

The new subsection (i)(1) would provide that a state must submit an application in a form and manner as specified by the CMS Administrator. The application would be required to include a description of how funds would be used for allowed activities ((i)(1)(A)); a certification that the state would, with non-Federal funds, make required contributions for allowed activities ((i)(1)(B)); a certification that funds would only be used for allowed activities ((i)(1)(C)); a certification that none of the funds would be used for prohibited activities, as specified ((i)(1)(D)); and other information as required by the CMS Administrator ((i)(1)(E)). Per new subsection (i)(3), a state would only need to apply once to be treated as providing applications for subsequent years. New subsection (i)(1) would provide that applications must be submitted no later than March 31 of the previous year (e.g., for CY2019 funds, applications must be submitted no later than March 31, 2018).

The new subsection (i)(4)(A) would authorize appropriations for the program and provide specific appropriation amounts (Table 1). The new subsection (i)(4)(B) would require that the CMS Administrator determine a methodology for allotting funds to states with approved applications under the program. The methodology for allotting funds to states would include reserving 1% of the appropriated funds in each calendar year for allotments to states where the health insurance premiums are at least 75% higher than the national average.

Under the new subsection (i)(5), from the state's allotment for the year, the federal government would only pay the federal percentage of the state's expenditures for the year. The federal percentage is 100% reduced by the state percentage for that year (Table 1); state expenditures would be required beginning CY2022.

In determining the allotments, the CMS Administrator would be required to ensure (per new subsection (i)(6)) that at least \$5 billion for each of CY2019-CY2021 would be used by states for allowed activities described in 2, above in accordance with guidance specifying the parameters for the use of the funds that the CMS Administrator would be required to issue no later than 30 days after enactment.

The new subsection (i)(4)(C) would provide that amounts allotted to a state would remain available for use by the state through the end of the second succeeding year. Beginning in 2021, amounts allotted and not used would be redistributed in accordance with a methodology specified by the CMS Administrator. Redistributed amounts would be available for use by the state through the end of the second succeeding year.

The new subsection (i)(7) lists limitations on expenditures under SSA Section 2105(c) that would not apply to payments made under the Long-Term State Stability and Innovation Program. The limitations under SSA Section 2105(c) that would apply to payments made under the program are paragraphs (1), related to prohibiting use of certain funds for health insurance coverage of abortion; (4), related to prohibiting federal funds for required state contributions; (7), related to prohibiting payment for abortion; and (9), related to citizenship documentation requirements.

Table I. Allotments Under the Long-Term State Stability and Innovation Program
As Would Be Established Under New Subsection (i) of SSA Section 2105

| Calendar Year | Allotment | | | Requirement on Use ^b |
|---------------|---------------------|--------------------|------------------|--|
| | Amount ^a | Federal Percentage | State Percentage | |
| 2019 | \$8.0 billion | 100% | 0% | For each of FY2019-FY2021, at least \$5 billion would be required to be used by states for activities to enter into arrangements with health insurance issuers for the purposes of stabilizing premiums and promoting market participation and plan choice in the individual market. |
| 2020 | \$14.0 billion | 100% | 0% | |
| 2021 | \$14.0 billion | 100% | 0% | |
| 2022 | \$19.2 billion | 93% | 7% | N.A. |
| 2023 | \$19.2 billion | 86% | 14% | N.A. |
| 2024 | \$19.2 billion | 79% | 21% | N.A. |
| 2025 | \$19.2 billion | 72% | 28% | N.A. |
| 2026 | \$19.2 billion | 65% | 35% | N.A. |

Notes: FY = Fiscal year. SSA = Social Security Act. N.A. = Not applicable. This table does not show amounts that would be appropriated under new subsection (h) of SSA Section 2105.

- a. The CMS Administrator would determine a methodology for allotting funds to states with approved applications under the program. The methodology for allotting funds to states would include reserving 1% of the appropriated funds in each calendar year for allotments to states where the health insurance premiums are at least 75% higher than the national average.
- b. The new subsection (i)(1) would provide that states may only use program funds for allowed activities. This column describes requirements on the use of program funds in addition to the requirement that program funds may only be used for the four activities described above.

Section 107. Better Care Reconciliation Implementation Fund

Section 107 would establish a Better Care Reconciliation Implementation Fund within HHS to provide for administrative expenses to carry out the draft bill. Section 107 would appropriate \$500 million to the fund.

Section 108. Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits

Section 108 would delay implementation of IRC Section 4980I (the so-called Cadillac tax) until taxable periods beginning January 1, 2026.

Section 109. Repeal of Tax on Over-the-Counter Medications

Section 109 would repeal the language in IRC Sections 106, 220, and 223 that stipulates that a medicine or drug must be a prescribed drug or insulin to be considered a qualified expense in terms of spending from a tax-advantaged health account. The provision would be generally effective beginning tax year 2017.

Section 110. Repeal of Tax on Health Savings Accounts

Section 110 would amend IRC Sections 220 and 223 to reduce the applicable rate to 15% and 10% for Archer MSAs and HSAs, respectively. The lower rates would apply to distributions made after December 31, 2016.

Section 111. Repeal of Limitations on Contributions to Flexible Spending Accounts

Section 111 would repeal IRC Section 125(i), the contribution limit for health FSAs, effective for plan years beginning in 2018.

Section 112. Repeal of Tax on Prescription Medications

Section 112 would amend ACA Section 9008(j) to provide that the tax would not be imposed effective CY2018.

Section 113. Repeal of Medical Device Excise Tax

Section 113 would amend IRC Section 4191 to provide that the medical device excise tax does not apply to sales after December 31, 2017.

Section 114. Repeal of Health Insurance Tax

Section 114 would amend ACA Section 9010(j) to provide that the annual fee would not be imposed effective CY2017.

Section 115. Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy

Section 115 would amend IRC Section 139A to reinstate prior law so that business-expense deductions for retiree prescription drug costs would be allowable without reduction by the amount of any federal subsidy. The change would be effective for taxable years beginning after December 31, 2016.

Section 116. Repeal of Chronic Care Tax

Section 116 would amend IRC Section 213(a) to reduce the AGI threshold to 7.5% for all taxpayers, effective tax year 2017.

Section 117. Repeal of Tanning Tax

Section 117 would repeal the tax on indoor tanning services (IRC Chapter 49), effective for services performed after September 30, 2017.

Section 118. Purchase of Insurance from Health Savings Account

Section 118 would amend IRC Section 223(d)(2)(A) to add that qualified medical expenses may include amounts paid for an account holder's children who are under the age of 27. The section would amend subparagraphs (B) and (C) of IRC Section 223(d)(2) to provide that HSA funds may be used to pay premiums for a high deductible health plan (HDHP) for which no deduction is allowed under IRC Section 162(l), that is not an employer-sponsored plan to which the exclusion under IRC Section 106 applies, and only for amounts that exceed any tax credit amounts allowed under IRC 36B. The amendments under this section would become effective in 2018.

Section 119. Maximum Contribution Limit to Health Savings Account Increased to Amount of Deductible and Out-of-Pocket Limitation

Section 119 would increase the HSA annual contribution limits for self-only and family coverage to match the out-of-pocket limits for HSA-qualified HDHPs for self-only and family coverage. The change would go into effect beginning in tax year 2018.

Section 120. Allow Both Spouses to Make Catch-Up Contributions to the Same Health Savings Account

Section 120 would amend IRC Section 223(b)(5) to provide that, with respect to the contribution limit to an HSA, married persons do not have to take into account whether their spouse is also covered by an HSA-qualified HDHP. In other words, spouses' aggregate contributions to their respective HSAs could be more than the annual contribution limit for family coverage. Their annual contribution limit would be reduced by any amount paid to Archer MSAs of either spouse for the taxable year, and then the remaining contribution amount would be divided equally between the spouses unless they agreed on a different division. If both spouses are eligible to make catch-up contributions before the close of the taxable year, then each spouse's catch-up contribution is included when dividing up the contribution amounts between the spouses. This provision would effectively allow both spouses to make catch-up contributions to one HSA and would apply to taxable years beginning in 2018.

Section 121. Special Rule for Certain Medical Expenses Incurred Before Establishment of Health Savings Account

Section 121 would amend IRC Section 223(d)(2) to provide a circumstance under which HSA withdrawals could be used to pay qualified medical expenses incurred before the HSA was established. If an HSA were established within 60 days of when an individual's coverage under an HSA-qualified plan begins, then the HSA would be treated as having been established on the date the coverage begins for purposes of determining whether an HSA withdrawal is used for a qualified medical expense. Section 121 would apply to coverage beginning after December 31, 2017.

Section 122. Exclusion from HSAs of High Deductible Health Plans Including Coverage for Abortion

Section 122 would amend IRC Section 223(d)(2)(C) to not allow HSA funds to be used to pay for an HDHP that provides coverage for abortions (except if necessary to save the life of the mother or if the pregnancy is the result of rape or incest), beginning in 2018.

Section 123. Federal Payments to States

Section 123 would prohibit federal funds made available to a state through direct spending from being provided to a prohibited entity (as defined), either directly or through a managed care organization, for a one-year period beginning upon enactment of the draft bill. The provision specifies that this prohibition would be implemented notwithstanding certain programmatic rules (e.g., the Medicaid freedom of choice of provider requirement that requires enrollees to be able to receive services from any willing Medicaid participating provider, and states cannot exclude providers solely on the basis of the range of services they provide).⁶ The section defines a "prohibited entity," as an entity that meets the following criteria at enactment: (1) it is designated as a not-for-profit by the IRS; (2) it is described as an essential community provider that is primarily engaged in family planning services, reproductive health, and related medical care; (3) it is an abortion provider that provides abortion in cases that do not meet the Hyde amendment exception for federal payment; and (4) it received more than \$350 million in Medicaid expenditures (both federal and state) in FY2014.

Section 124. Medicaid Provisions

Sections 124(1) and 124(3). Presumptive Eligibility

After January 1, 2020, Section 124(1) would no longer allow hospitals that participate in Medicaid to elect to make presumptive-eligibility determinations, and would provide that any such election that a hospital had already made would cease to be effective as of that date by modifying SSA Section 1902(a)(47)(B).

On January 1, 2020, Section 124(3) would terminate the authority of certain specified states (i.e., those that elected to provide a presumptive-eligibility period to children or pregnant women) to elect to make presumptive-eligibility determinations for the ACA Medicaid expansion group or the state option for coverage for individuals with income that exceeds 133% of FPL by modifying SSA Section 1920(e). The provision would not modify the authority of such states to elect to make presumptive-eligibility determinations for the mandatory foster care group under the age of 26 or for low-income families eligible under SSA Section 1931 based on a preliminary determination of likely Medicaid eligibility by a specified Medicaid provider.

Section 124(2). Federal Medicaid Matching Rate for Community First Choice Option

Section 124(2) would repeal the increased FMAP rate for the Community First Choice option on January 1, 2020, by modifying SSA Section 1915(k)(2).

Section 125. Medicaid Expansion

Section 125(a)(1)(A)(i). ACA Medicaid Expansion

Section 125(a)(1)(A)(i) would codify the ACA Medicaid expansion as optional for states after December 31, 2019, by specifying the end date of the ACA Medicaid expansion (at SSA Section 1902(a)(10)(A)(i)(VIII)) as December 31, 2019, and adding a new Medicaid optional eligibility group (at SSA Section 1902(a)(10)(a)(ii)(XXIII)) beginning January 1, 2020.

Section 125(a)(1)(A)(ii). State Option for Coverage for Non-elderly Individuals with Income That Exceeds 133% of FPL

Section 125(a)(1)(A)(ii) would repeal the state option to extend coverage to non-elderly individuals above 133% of FPL (SSA Section 1902(a)(10)(A)(ii)(XX)) by specifying an end date of December 31, 2017.

Section 125(a)(1)(B). Definition of Expansion Enrollees

Section 125(a)(1)(B) would incorporate the existing ACA expansion enrollee definition for the purposes of the new optional Medicaid eligibility group for expansion enrollees. The provision would also apply this definition to existing provisions in Medicaid statute that currently reference the ACA Medicaid expansion group (i.e., SSA Section 1902(a)(10)(A)(i)(VIII)), including provisions related to payments to states, medical assistance, alternative benefit plan (ABP) coverage, and presumptive eligibility, among others.

Section 125(a)(2)(A). Newly Eligible Federal Matching Rate

For states that implemented the ACA Medicaid expansion as of March 1, 2017, Section 125(a)(2)(A) would maintain the current structure of the newly eligible matching rate for expenditures through CY2020. The newly eligible matching rate would phase down to 85% in CY2021, 80% in CY2022, and 75% in CY2023. However, if a state's regular FMAP rate in any year is higher than the newly eligible

matching rate, the state's regular matching rate would apply. The newly eligible matching rate would not be available to states after CY2023.

States that implement the expansion after February 28, 2017 would not be eligible for the newly eligible matching rate, and these states would receive their regular matching rate to cover the newly eligible expansion enrollees.

Section 125(a)(2)(B). Expansion State Federal Matching Rate

Section 125(a)(2)(B) would amend SSA Section 1905(z)(2) by amending the formula for the expansion state matching rate so that the matching rate would stop phasing up after CY2017 and the transition percentage would remain at the CY2017 level through CY2023. However, if a state's regular FMAP rate in any year is higher than the state's expansion state matching rate, the state's regular matching rate would apply. The expansion state matching rate would not be available to states after CY2023.

Section 125(b). Sunset of Medicaid Essential Health Benefits Requirement

Section 125(b) would specify that SSA Section 1937(b)(5) would not apply after December 31, 2019. This means that Medicaid ABP coverage would no longer be required to include the EHB after that date.

Section 126. Restoring Fairness in DSH Allotments

Section 126 would amend SSA Section 1923(f) by exempting non-expansion states from the ACA Medicaid DSH allotment reductions, and the Medicaid DSH allotment reductions for expansion states would be determined as though non-expansion states were not exempted from the reductions.

In addition, certain non-expansion states would receive an increase to their Medicaid DSH allotments for FY2020. Starting the second quarter of CY2024, Medicaid DSH allotments for states receiving the increase would be determined as though the states had not received the increase in FY2020.

Non-expansion states would receive the increase to their Medicaid DSH allotment in FY2020 if their per capita FY2016 Medicaid DSH allotment amount (i.e., FY2016 Medicaid DSH allotment divided by the number of uninsured individuals in the state for such fiscal year) is below the national average per capita FY2016 Medicaid DSH allotment amount. Eligible states would receive an increase to their FY2020 Medicaid DSH allotment that would be the difference between each state's per capita FY2016 Medicaid DSH allotment amount and the national average per capita FY2016 Medicaid DSH allotment amount.

For this provision, *expansion state* would be defined with respect to a fiscal year as a state that provides eligibility under the ACA Medicaid expansion or the state option for coverage for individuals with incomes that exceed 133% of FPL on or after January 1, 2021.

A *non-expansion state* would be defined as a state that is not an expansion state with respect to a fiscal year. However, a state that provides eligibility under the ACA Medicaid expansion or the state option for coverage for individuals with incomes that exceed 133% of FPL during the period of October 1, 2017 through December 31, 2020 would be treated as a non-expansion state for quarters beginning on or after the first day of the first month for which the state no longer provides such coverage.

Section 127. Reducing State Medicaid Costs

Section 127 would amend SSA Sections 1902(a)(34) and 1905(a) to limit the effective date for retroactive coverage of Medicaid benefits to the month in which the applicant (or individual acting on behalf of a deceased individual) applied, with certain specified exceptions. Specifically, the provision would continue to require states to provide for retroactive Medicaid coverage for services provided in or after the third month before the month of application for (1) recipients who are 65 years of age or older, and (2) individuals who are eligible for medical assistance on the basis of being blind or disabled at the time the

application is made. This provision would apply to Medicaid applications made (or deemed to be made) on or after October 1, 2017.

Section 128. Providing Safety Net Funding for Non-Expansion States

Section 128 would add a new Section 1923A to the SSA to establish safety-net funding for non-expansion states. For FY2018 through FY2022, each state (defined as the 50 states and the District of Columbia) that has not implemented the ACA Medicaid expansion (through the state plan or a waiver) as of July 1 of the preceding year may receive safety-net funding to adjust payment amounts for Medicaid providers. For these payment adjustments using the safety-net funding, non-expansion states would receive an increased matching rate of 100% for FY2018 through FY2021 and 95% for FY2022. The maximum amount of safety-net funding for all non-expansion states would be \$2.0 billion for each year, for a total of \$10 billion from FY2018 through FY2022. Each non-expansion state's allotment for each year would be determined according to the number of individuals in the state with income below 138% of FPL in 2015 relative to the total number of individuals with income below 138% of FPL for all the non-expansion states in 2015. The 2015 American Community Survey one-year estimates as published by the Bureau of the Census would be used to determine the portion of each state's population that is below 138% of FPL.

The payment adjustments to providers would not exceed the provider's costs incurred to furnish health care services for Medicaid enrollees or the uninsured. The provider's costs would be determined by the HHS Secretary, and the costs would be net of other Medicaid payments and payments from uninsured patients. If a non-expansion state were to implement the ACA Medicaid expansion, the state would no longer be treated as a non-expansion state for safety-net funding for subsequent years.

Section 129. Eligibility Redeterminations

Section 129(a). Frequency of Eligibility Redeterminations

Beginning October 1, 2017, Section 129(a) would amend SSA Section 1902(e)(14) to permit states to redetermine Medicaid eligibility every six months (or more frequently) for individuals eligible for Medicaid through (1) the ACA Medicaid expansion or (2) the state option for coverage for individuals with income that exceeds 133% of FPL.

Section 129(b). Increased Administrative Matching Percentage for Eligibility Redeterminations

Section 129(b) would increase the federal match for the administrative activities attributable to the option under Section 129(a) of redetermining Medicaid eligibility every six months (or more frequently) by five percentage points. This increased federal match would be available from October 1, 2017, through December 31, 2019.

Section 130. Optional Work Requirement for Nondisabled, Nonelderly, Nonpregnant Individuals

Section 130(a). State Option for Work Requirements

Section 130(a) would modify SSA Section 1902 by adding a new subsection (oo) to permit states, effective October 1, 2017, to require nondisabled, non-elderly, nonpregnant individuals to satisfy a work requirement as a condition for receipt of Medicaid medical assistance. The provision would define *work requirements* as an individual's participation in work activities for a specified period of time as administered by the state. The provision would incorporate, by reference, the definition of work activities as they appear in SSA Section 407(d) under Part A of Title IV (Block Grants to States for TANF), and would include:

- “unsubsidized employment;

- subsidized private-sector employment;
- subsidized public-sector employment;
- work experience (including work associated with the refurbishing of publicly assisted housing) if sufficient private-sector employment is not available;
- on-the-job training;
- job search and job readiness assistance;
- community service programs;
- vocational educational training (not to exceed 12 months with respect to any individual);
- job skills training directly related to employment;
- education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency;
- satisfactory attendance at secondary school or a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate; and
- the provision of child-care services to an individual who is participating in a community service program.”

Participating states would be required to exempt the following groups from participation in the work requirement: (1) pregnant women (for the duration of the pregnancy and through the end of the month in which the 60-day postpartum period ends); (2) individuals under 19 years of age; (3) an individual who is the sole parent or caretaker relative in the family of (a) a child who is under the age of 6 or (b) a child with disabilities; or (4) an individual who is less than 20 years of age, who is married or a head of household and who (a) maintains satisfactory attendance at secondary school or the equivalent or (b) participates in education directly related to employment.

Section 130(b). Increase in Matching Rate for Implementation of Work Requirement

Section 130(b) would increase the federal match for administrative activities to implement the work requirement under Section 130(a) by five percentage points in addition to any other increase to such federal matching rate.

Section 131. Provider Taxes

Section 131 would phase down the Medicaid provider tax threshold from the current level of 6% to 5.8% in FY2021, 5.6% in FY2022, 5.4% in FY2023, 5.2% in FY2024, and 5.0% in FY2025 and subsequent fiscal years.

Section 132. Per Capita Allotment for Medical Assistance

Section 132(a). Per Capita Allotment for Medical Assistance

Section 132(a) would reform federal Medicaid financing to a per capita cap model (i.e., per enrollee limits on federal payments to states) starting in FY2020. Specifically, each state’s spending during the state-selected base period would be the base to set targeted spending for each enrollee category in FY2019 and subsequent years for that state. Each state’s targeted spending amounts would increase annually by the applicable annual inflation factor, which varies by enrollee category. Starting in FY2020, any state with spending higher than its specified targeted aggregate amount would receive reductions to its Medicaid funding for the following fiscal year. One provision would reduce the target amount for New York if certain local government contributions to the state share are required.

Section 132(a)(1) would add references to new SSA Section 1903A that is explained below in SSA Section 1903. SSA Section 1903 lays out how the federal government makes payments to states for the Medicaid program.

Section 132(a)(2) would add a new SSA Section 1903A. The following provides a description of what would be the new SSA Section 1903A.

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

Under Section (a) of the new SSA Section 1903A, beginning in FY2020, if a state has *excess aggregate medical assistance expenditures* for a fiscal year, the state's quarterly Medicaid payments from the federal government for the following fiscal year would be reduced by one-quarter of the *excess aggregate medical assistance payments* for the previous fiscal year. This section would be applicable to the 50 states and the District of Columbia.

Excess aggregate medical assistance expenditures for the state and fiscal year would be the amount by which the *adjusted total medical assistance expenditures* (defined under Section (b) of the new SSA Section 1903A) exceeds the amount of *target total medical assistance expenditures* (defined under Section (c) of the new SSA Section 1903A).

Excess aggregate medical assistance payments would be the product of the *excess aggregate medical assistance expenditures* and the *federal average medical assistance matching percentage*.

The *federal average medical assistance matching percentage* for each state and fiscal year would be the ratio of (1) the amount of federal payments made to the state under SSA Section 1903(a)(1) for *medical assistance expenditures* in the fiscal year prior to any potential reduction applied under this section to (2) the amount of the state's total medical assistance expenditures for the fiscal year (including both federal and state expenditures).

The *per capita base period* for each state would be a period of eight consecutive fiscal quarters selected by the state no later than January 1, 2018. The state would need to select a period (1) for which all the data necessary to make the determinations for the *per capita base period* as determined by the HHS Secretary is available and (2) that begins as early as the first quarter of FY2014 and ends no later than the third quarter of FY2017. The HHS Secretary would be able to make adjustments to a state's data if the state took action to diminish the quality of the data (including making retroactive adjustments to supplemental payments) for the *per capita base period* after the date of enactment of this section. For states that did not implement the ACA Medicaid expansion as of the first day of the fourth fiscal quarter of FY2015 and implemented the expansion in a subsequent fiscal quarter that is not later than the fourth quarter of FY2016, the state may select a base period that is between four and eight consecutive fiscal quarters.

Section (b). Adjusted Total Medical Assistance Expenditures

Under Section (b), there would be two formulas for *adjusted total medical assistance expenditures*: one formula for the *per capita base period* and another formula for FY2019 and subsequent years. Both formulas for *adjusted total medical assistance expenditures* would exclude expenditures for Medicaid DSH payments under SSA Section 1923, Medicare cost-sharing payments under SSA Section 1905(p)(3), safety-net provider payment adjustments in non-expansion states,² and expenditures for public health emergencies for calendar years 2020 through 2024 (discussed below).

The *per capita base period* formula for *adjusted total medical assistance expenditures* would be the product of (1) the amount of *medical assistance expenditures* for a state reduced by the amount of any *excluded expenditures* in the base period and (2) the *1903A* base period *population percentage*, which is

² Section 128 would add a new §1923A to the SSA to establish safety-net funding for non-expansion states.

the HHS Secretary's calculation of the percentage of actual *medical assistance expenditures* attributable to *1903A enrollees* in a state in the base period (discussed below, under Section (e)). The base period medical assistance expenditures and excluded expenditures would be the total amount of expenditures divided by two.³

The FY2019 or subsequent fiscal years formula for *adjusted total medical assistance expenditures* for a state and fiscal year would be the amount of *medical assistance expenditures* attributable to *1903A enrollees* reduced by any *excluded expenditures*.

Medical assistance expenditures would be defined as medical assistance payments as reported under the medical services category on the Form CMS-64 quarterly expense report (or successor to such form) for which payment is made pursuant to SSA Section 1903(a)(1).

The language specifies that the medical assistance expenditures for FY2019 and subsequent years would include *non-DSH supplemental payments* (including certain waiver expenditures for delivery system reform incentive pools, uncompensated care pools, and designated state health programs). The medical assistance expenditures for FY2019 and subsequent years would not include expenditures for the Vaccines for Children program.

The excluded expenditures for public health emergencies from January 1, 2020 through December 31, 2024 would be medical assistance expenditures during the period of a public health emergency declared by the HHS Secretary pursuant to the Public Health Service Act (PHSA) Section 319 that the HHS Secretary determines would be appropriate to exclude from the Medicaid per capita caps. The maximum amount of excluded expenditures for public health emergencies in a given fiscal year would be equal to the amount by which (1) medical assistance expenditures for *1903A enrollees* in areas of the state subject to public health emergency declarations during the period of such declarations exceeds (2) the medical assistance expenditures for such enrollees in such area during the most recent fiscal year or portion of a fiscal year of equal length before the public health emergency was declared. If a state has funds excluded from the per capita caps due to a public health emergency, then the HHS Secretary would be required to audit the impacted medical assistance expenditures no later than six months after the public health emergency declaration. The aggregate limit for excluded expenditures for public health emergencies under the per capita caps and additional federal funds under the block grant option (in Section 133) would be \$5 billion for the period of January 1, 2020 through December 31, 2024.

Section (c). Target Total Medical Assistance Expenditures

Under Section (c) of the new SSA Section 1903A, *target total medical assistance expenditures* for a state and fiscal year would be the sum of the following formula for each *1903A enrollee category* (defined under Section (e) of the new SSA Section 1903A): (1) *target per capita medical assistance expenditures* for the enrollee category times (2) the number of *1903A enrollees* for such *1903A enrollee category*.

For FY2020, the *target per capita medical assistance expenditures* for each *1903A enrollee category* would be the *provisional FY2019 target per capita amount* (defined in Section (d) of the new SSA Section 1903A) for such enrollee category for the state increased by the applicable annual inflation factor. For subsequent years, the *target per capita medical assistance expenditures* for each *1903A enrollee category* would be the *target per capita medical assistance expenditures* for the previous year for such enrollee category for the state increased by the applicable annual inflation factor.

The applicable inflation factor would vary by *1903A enrollee category* before FY2025. For the children; expansion enrollee; and other non-elderly, nondisabled, non-expansion adult categories, the applicable inflation factor before FY2025 would be the percentage increase in the medical care component of the

³ If the base period is less than eight consecutive fiscal quarters, the expenditures would be divided by the ratio that the number of quarters in the base period bears to four.

CPI-U from September of the previous fiscal year to September of the fiscal year involved. For the elderly and disabled categories, the applicable inflation factor before FY2025 would be the percentage increase in the medical care component of the CPI-U from September of the previous fiscal year to September of the fiscal year involved *plus one percentage point*. For FY2025 and subsequent years, the applicable inflation factor for all *1903A enrollee categories* would be CPI-U from September of the previous fiscal year to September of the fiscal year involved.

Beginning in FY2020, there would be a decrease in the *target total medical assistance expenditures* for states that (1) have a Medicaid DSH allotment in FY2016 that was more than six times the national average and (2) require political subdivisions within the state to contribute funds toward medical assistance or other expenditures under Medicaid (including under a waiver) for the fiscal year involved. The decrease would be the amount that political subdivisions in the state are required to contribute under Medicaid without reimbursement from the state other than the following required contributions: (1) from political subdivisions with a population of more than 5 million that impose local income tax upon their residents and (2) for certain administrative expenses required to be paid by the political subdivision as of January 1, 2017.

Also, beginning in FY2020, a state's *target per capita medical assistance expenditures* for each *1903A enrollee category* would be adjusted if the state's *per capita categorical medical assistance expenditures* for the preceding fiscal year exceeds or is less than the mean *per capita categorical medical assistance expenditures* for the enrollee category in all states by 25.0%. The adjustment would be a decrease for expenditures that exceed 25.0% of the mean and an increase for expenditures that are less than 25.0% of the mean that would not be less than 0.5% or greater than 2.0%. The HHS Secretary would determine the amount of the increase or decrease, and the adjustments would be required to be budget neutral (i.e., would not result in a net increase of federal payments under the per capita caps for the fiscal year). The adjustments would not apply to low density states (i.e., any state with population density of less than 15 individuals per square mile). The adjustments would be disregarded when determining the *target medical assistance expenditures* for the succeeding fiscal year. For FY2020 and FY2021, the HHS Secretary would apply the adjustment by deeming all enrollee categories to be a single category.

For each state and fiscal year, *per capita categorical medical assistance expenditures* would be the *categorical medical assistance expenditures* (i.e., *medical assistance expenditures* for an enrollee category minus the *excluded expenditures*) divided by the number of *1903A enrollees* in the enrollee category.

Section (d). Calculation of FY2019 Provisional Target Amount for Each 1903A Enrollee Category

The HHS Secretary would calculate for each state the *provisional FY2019 per capita target amounts* for each *1903A enrollee category*. The formula for the *provisional FY2019 per capita target amounts* would be the *average per capita medical assistance expenditures* for the state for FY2019 for such enrollee category multiplied by the ratio of (1) the product of the FY2019 *average per capita amount* for the state and the number of *1903A enrollees* for the state in FY2019 to (2) the amount of FY2019 *adjusted total medical assistance expenditures* for the state. This calculation would be subject to treatment of states expanding coverage after FY2016 (discussed in Section (f) of the new SSA Section 1903A).

The *average per capita medical assistance expenditures* for FY2019 for each *1903A enrollee category* would be the FY2019 *adjusted total medical assistance expenditures* for the state divided by the number of *1903A enrollees* for the state in FY2019. The FY2019 *adjusted total medical assistance expenditures* would exclude *non-DSH supplemental expenditures* (including certain waiver expenditures for delivery system reform incentive pools, uncompensated care pools, and designated state health programs) for FY2019 and would be increased by the *non-DSH supplemental payment percentage* for the base period, which is the ratio of

- the total amount of *non-DSH supplemental payments* for the base period divided by two to
- *adjusted total medical assistance expenditures* for the base period.

For each state, the FY2019 *average per capita amount* would be the base period *average per capita medical assistance expenditures* increased by the percentage increase in the medical care component of the CPI-U from the last month of the base period to September of FY2019. The base period *average per capita medical assistance expenditures* would be the amount of the base period *adjusted total medical assistance expenditures* (discussed in Section (b)) divided by the number of 1903A enrollees for the state in the base period.

Section (e). 1903A Enrollee; 1903A Enrollee Category

This section would define *1903A enrollees* as Medicaid enrollees (i.e., individuals eligible for medical assistance under Medicaid and enrolled under the Medicaid state plan or waiver) for the month in a state that is not covered under the block grant option and does not fall into one of the following categories:

- individuals covered under a CHIP Medicaid expansion program (SSA Section 2101(a)(2)),
- individuals who receive medical assistance through an Indian Health Service facility (the third sentence under SSA Section 1905(b)),
- individuals eligible for medical assistance coverage of breast and cervical cancer treatment due to screening under the Breast and Cervical Cancer Early Detection Program (SSA Section 1902(a)(10)(A)(ii)(XVIII)),
- blind and disabled children under the age of 19, or
- the following partial-benefit enrollees:
 - unauthorized (illegally present) aliens eligible for Medicaid emergency medical care (SSA Section 1903(v)(2)),
 - individuals eligible for Medicaid family planning options (SSA Section 1902(a)(10)(A)(ii)(XXI)),
 - individuals infected with tuberculosis (SSA Section 1902(a)(10)(A)(ii)(XII)),
 - dual-eligible individuals eligible for coverage of Medicare cost sharing (SSA Section 1905(p)(3)(A)(i) or (ii)), or
 - individuals eligible for premium assistance (SSA Section 1906 or 1906A).

The enrollment count would be based on the average monthly amount reported through the Form CMS-64 as required under Section (h).

The *1903A enrollee categories* would be (1) elderly; (2) blind and disabled adults; (3) children; (4) expansion enrollees; and (5) other non-elderly, nondisabled, non-expansion adults.

Section (f). Special Payment Rules

Section (f) of the new SSA Section 1903A would provide special payment rules for (1) payments made under Section 1115 waivers or Section 1915 waivers, (2) states that did not have the ACA Medicaid expansion as of July 1, 2016 and later implement the expansion, and (3) states that fail to satisfactorily submit data in accordance with Section (h)(1) of the new SSA Section 1903A.

Section (g). Recalculation of Certain Amounts for Data Errors

Section (g) of the new SSA Section 1903A would allow for the recalculation of certain amounts for data errors. Any adjustment under this section would not result in an increase of the *target total medical assistance expenditures* exceeding 2%.

Section (h). Required Reporting and Auditing; Transitional Increase in Federal Matching Percentage for Certain Administrative Expenses

In addition to the required reporting for ACA Medicaid expansion on the Form CMS-64 report as of January 1, 2017, Section (h) of the new SSA Section 1903A would impose additional reporting requirements on states starting October 1, 2018. The additional reporting requirements would include data on medical assistance expenditures within categories of services and categories of enrollees (including each *1903A enrollee category* and the enrollment categories excluded from the definition of *1903A enrollees*). In addition, Section (h) would require reporting of the number of enrollees within each enrollee category. The HHS Secretary would determine the specific reporting requirements.

States would also be required to report medical assistance expenditures for qualified inpatient psychiatric hospital services on the Form CMS-64.⁴ The HHS Secretary would modify the Form CMS-64 no later than 60 days after the date of enactment.

The HHS Secretary would also modify the Form CMS-64 no later than January 1, 2020 to require states to report data about children with complex medical conditions. Specifically, states would be required to report information about individuals enrolled in Medicaid or CHIP who are under the age of 21 and have a chronic medical condition that either (1) requires intensive healthcare interventions or (2) meets the criteria for medical complexity.

The HHS Secretary would conduct audits of each state's enrollment and expenditures reported on the Form CMS-64 for the *base period*, FY2019, and subsequent years. These audits may be conducted on a representative sample, as determined by the HHS Secretary. The HHS Inspector General also would audit each state's spending under the per capita caps at least every three years.

For states that select the most recent eight consecutive fiscal quarter period for its base period, this section would provide a temporary increase to the federal matching percentage for the administrative activities related to improving data reporting systems. The temporary increases would impact expenditures on or after October 1, 2017, and before October 1, 2019.

The HHS Secretary would submit a report no later than January 1, 2025 making recommendations about whether data from the Transformed Medicaid Statistical Information System (T-MSIS) would be preferable to CMS-64 data for the purpose of making determinations for the per capita caps.

Section 132(b). Ensuring Access to Home and Community-Based Services

Section 132(b) would establish a new SSA Section 1915(l) to require the HHS Secretary to establish a four year demonstration project under which eligible states may make HCBS payment adjustments for the purpose of continuing to provide and improving the quality of HCBS under a Section 1915(c) or (d) waiver or the Section 1915(i) HCBS state plan option. Participating states would be selected on a competitive basis with priority given to any one of the 15 states with the lowest population density, as determined by the HHS Secretary based on data from the U.S. Census Bureau. The demonstration project would begin on January 1, 2020 and end on December 31, 2023. Under the demonstration, each state would receive an amount allotted for each year with the aggregate amount allotted to eligible states for all years not to exceed \$8 billion.

⁴ Section 137 would provide states the option to provide coverage of qualified inpatient psychiatric hospital services for certain Medicaid enrollees.

The HCBS payment adjustment would be an adjustment made by an eligible state to the amount of payment otherwise provided for HCBS under a Section 1915(c) or (d) waiver or the Section 1915(i) HCBS state plan option provided to a *1903A enrollee* [as defined in the new Section 132(a) of the draft bill] who is in either the elderly or blind and disabled enrollee category. For each year of the demonstration project, expenditures by eligible states would receive a 100% federal matching rate (i.e., fully federal funded) for the HCBS payment adjustments, subject to certain limitations for: (1) payments to individual providers; and (2) annual state allotment amounts. Each eligible state would be required to collect and report information, as determined by the HHS Secretary

Section 133. Flexible Block Grant Option for States

Section 133 would give states the option to participate in the Medicaid Flexibility Program beginning with FY2020. Under the Medicaid Flexibility Program, states would receive block grant funding (i.e., a predetermined fixed amount of federal funding) instead of per capita cap funding for non-elderly, nondisabled, non-expansion adults. Some statutory requirements would not apply under the block grant option, and states would elect this option for a five-year period.

Section 133 would add a new SSA Section 1903B. The following provides a description of what would be the new SSA Section 1903B.

Section (a). In General

Beginning in FY2020, states (defined as the 50 states and the District of Columbia) would have the option to have a Medicaid Flexibility Program, which is a state program for providing *targeted health assistance* to *program enrollees* funded by a block grant.

The *applicable program enrollee category* with respect to a state's Medicaid Flexibility Program for a program period would be specified by the state, and the *applicable program enrollee category* would include (1) expansion enrollees (as defined by SSA Section 1903A(e)(2)(D)), (2) non-elderly, nondisabled, non-expansion adults (as defined in SSA Section 1903A(e)(2)(E)), or (3) both of those groups.⁵

Targeted health assistance would be defined as assistance for healthcare-related items and medical services for *program enrollees*. This definition is from Section (e).

Program enrollee would be defined as an individual who is included in the *applicable program enrollee category* specified by the state. This definition is from Section (e).

The *program period* for a state's Medicaid Flexibility Program would be defined as a period of five consecutive fiscal years that begin with either (1) the first fiscal year in which the state has the program or (2) the next fiscal year in which the state has such a program that begins after the end of a previous *program period*. This definition is from Section (e).

Section (b). State Application

States would need to submit an application to be eligible to participate in the Medicaid Flexibility Program. The application would need to include the following list of items.

1. A description of the proposed Medicaid Flexibility Program and how the states would satisfy the program requirements.
2. The proposed conditions of eligibility of *program enrollees*.
3. The *applicable program enrollee category*.

⁵ Section 132 would establish SSA Section 1903A, which would reform federal Medicaid financing to a per capita cap model.

4. A description of the types, amount, duration, and scope of services covered.
5. A description of how the state would notify current Medicaid enrollees of the transition to the Medicaid Flexibility Program.
6. Statements certifying that the state report the required data and information, including enrollment data; T-MSIS data; adult quality health measures; additional information as determined by the HHS Secretary; and annual program evaluation.
7. An information technology systems plan.
8. A statement of goals for the proposed program with a plan for monitoring and evaluating the goals are met and plan for remedial action if goals are not met.

Before submitting the application, states would need to make the application publicly available for a 30 day notice and comment period. During the notice and comment period, the state would provide opportunities for meaningful public input. The HHS Secretary would not approve the application for the program without the notice and comment period.

Each year beginning with 2019, the HHS Secretary would specify a deadline for a state to submit an application to have a Medicaid Flexibility Program that would begin in the next fiscal year. The deadline would be no earlier than 60 days after the date the HHS Secretary publishes states' amount of block grant funds for the next fiscal year.

Section (c). Financing

For each year a state has a Medicaid Flexibility Program, the state would receive block grant funds rather than per capita cap funding for the *program enrollees*. The block grant amounts would be equal to the sum of the amounts calculated for each 1903A enrollee category within the *applicable program enrollee category*.

For the first fiscal year a state includes an enrollee category in their Medicaid Flexibility Program, the amount calculated for the enrollee category would be equal to the *federal average medical assistance matching percentage* for the state and year multiplied by the product of (1) the *target per capita medical assistance expenditures* for the enrollee category and (2) the number of enrollees in the category for the second fiscal year preceding such first fiscal year increased by the percentage increase in the state population from such second preceding fiscal year to the first fiscal year based on estimates from the Bureau of Census.⁶

In calculating each state's amounts for the first fiscal year in which each enrollee category is included in the Medicaid Flexibility Program, the total number of enrollees for the fiscal year and category would not exceed the adjusted number of base period enrollees. The adjusted number of base year enrollees for each state would be the number of enrollees for the state's *per capita base period* increased by the percentage increase (if any) in total state population from the last April in the state's *per capita base period* to the April of the fiscal year preceding the fiscal year involved plus three percentage points.⁷

For subsequent years, states' amounts for each enrollment category would be the amount from the previous fiscal year increased by the percentage increase in the CPI-U from April of the second fiscal year preceding the fiscal year involved to April of the fiscal year preceding the fiscal year involved.

States could receive federal funds in addition to the block grant amount if a state has medical assistance expenditures excluded from the Medicaid per capita caps for public health emergencies from January 1,

⁶ The terms *federal average medical assistance matching percentage* and *target per capita medical assistance expenditures* are defined in Section 132.

⁷ The term *per capita base period* is defined in Section 132.

2020 through December 31, 2024. If a state has *uncompensated targeted health assistance*, the HHS Secretary would be able to make additional payments to the state equal to the *federal average medical assistance matching percentage* of the *uncompensated targeted health assistance* during the period of the public health declaration. The *uncompensated targeted health assistance* would be the amount by which (1) total expenditures for targeted health assistance during the period of the declaration exceeds (2) the block grant amount divided by the *federal average medical assistance matching percentage*. The maximum federal payment a state could receive would be the amount by which (1) state expenditures for the targeted health assistance in the area of the state subject to the public health emergency declaration during the period of the declaration exceeds (2) the state expenditures for targeted health assistance for such enrollees in such area during the most recent fiscal year or portion of a fiscal year of equal length before the public health emergency was declared. If a state receives this additional federal payment, then the HHS Secretary would be required to audit the impacted targeted health assistance expenditures no later than six months after the public health emergency declaration.⁸

If the block grant amount for a state exceeds the federal payments to a state for a fiscal year, the excess block grant funds would be available to the states for the succeeding fiscal year if the state satisfies the maintenance of effort requirement and has the Medicaid Flexibility Program in the succeeding fiscal year. These rollover funds would be used for states' Medicaid state plan or the Medicaid Flexibility Program.

Each state would be paid quarterly from their annual block grant amount an amount equal to the *federal average medical assistance percentage* of the total amount expended for the Medicaid Flexibility Program during such quarter. The state would be responsible for funding the rest of the program.

The state maintenance of effort expenditures under the Medicaid Flexibility Program would require states to have expenditures for each year under the program equal to the product of (1) each state's block grant amount for the fiscal year and (2) E-FMAP rate used for CHIP.⁹

States that fail to meet the maintenance of effort requirement for a fiscal year would receive a reduction to their block grant amount for the succeeding fiscal year. The reduction would be the amount by which the state expenditures were less than the required amount, and this reduction would be disregarded for determining the block grant amount in the year after the reduction is applied. For states that terminate the Medicaid Flexibility Program and the termination is effective with the end of a fiscal year in which the state doesn't meet the maintenance of effort requirement, the reduction amount would be treated as a Medicaid overpayment.

The HHS Secretary would be able to withhold payment, reduce payment, or recover previous payment under the Medicaid Flexibility Program for states that are not in compliance with the program requirements.

Beginning in 2019 and each year thereafter, the HHS Secretary would be required to determine the block grant amount for all states for the upcoming fiscal year. The amounts would be published no later than June 1 of each year.

Section (d). Program Requirements

No payment would be made to a state under the Medicaid Flexibility Program unless the state's program meets all of the Medicaid Flexibility Program requirements.

⁸ Section 132(a) would establish an aggregate limit for the excluded expenditures for public health emergencies under the per capita caps and additional federal funds under the block grant option that would be \$5 billion for the period of January 1, 2020 through December 31, 2024.

⁹ The enhanced federal medical assistance percentage (E-FMAP) rate is based on the FMAP rate, and the E-FMAP rate is calculated by reducing the state share under the regular FMAP rate by 30.0%. Statutorily, the E-FMAP can range from 65.0% to 85.0%.

States would have the Medicaid Flexibility Program for not less than one *program period* (i.e., five consecutive fiscal years). States would have the option to continue the Medicaid Flexibility Program for succeeding *program periods* without resubmitting an application provided that (1) the state provides notice to the HHS Secretary and (2) no significant changes are made to the program.

The Medicaid Flexibility Program would be subject to termination only by the state. In order to elect to terminate the program, a state would be required to have an appropriate transition plan approved by the HHS Secretary. A state's termination would be effective the first day after the end of the *program period*, and after the termination of the program, the state would receive per capita cap funding as if the state had never had the Medicaid Flexibility Program.

States would be able to provide *targeted health assistance* coverage to the *program enrollees* that could be different from the medical assistance provided to other Medicaid enrollees not under the Medicaid Flexibility Program. States would be able to establish the conditions of eligibility that could be different from the conditions of eligibility for the rest of Medicaid, but states would be required to provide coverage to *program enrollees* that are currently required to be covered by Medicaid programs under SSA Section 1902(a)(10)(A)(i). States would be required to use the MAGI counting rules to establish eligibility for *program enrollees*.

For *program enrollees* whom the state is currently required to provide Medicaid coverage under SSA Section 1902(a)(10)(A)(i), states would be required to provide *targeted health assistance* and the Medicaid Flexibility Program that includes the following types of services: inpatient and outpatient hospital services; laboratory and x-ray services; nursing facility services for individuals aged 21 and over; physician services; home health care services; rural health clinic services; federally-qualified health centers; family planning services and supplies; nurse midwife services; certified pediatric and family nurse practitioner services; freestanding birth center services; emergency medical transportation; non-cosmetic dental services; and pregnancy services.

States would also be able to provide coverage of optional benefits not listed as a required service under the Medicaid Flexibility Program.

The *targeted health assistance* provided to any group of *program enrollees* would be required to have (1) an aggregate actuarial value equal to at least 95% of the aggregate actuarial value of the benchmark coverage from SSA Section 1937(b)(1) that was in effect prior to the enactment of the ACA or (2) benchmark-equivalent coverage from SSA Section 1937(b)(2) that was in effect prior to the enactment of the ACA.

States would be able to determine the amount, duration, and scope of the *targeted health assistance* provided to all *program enrollees* except for as otherwise specified.

The *targeted health assistance* would be required to provide mental health and substance use disorder coverage that complies with federal mental health parity requirements. Also, if a state provides coverage of prescription drug to *program enrollees*, then the prescription drugs would be subject to a rebate agreement that complies with the requirements of SSA Section 1927.

Under the Medicaid Flexibility Program, states would be able to impose premiums, deductibles, cost-sharing, or other similar charges as long as the total annual aggregate amount of all such charges does not exceed 5% of the family's annual income.

States would be required to designate a single agency to administer the Medicaid Flexibility Program. States with Medicaid Flexibility Programs would be required (1) to provide for simplified enrollment processes and coordination with state health insurance exchanges and (2)

Section 134. Medicaid and CHIP Quality Performance Bonus Payments

Section 134 would establish Medicaid and CHIP quality performance bonus payments for FY2023 through FY2026. To be eligible for the Medicaid and CHIP quality performance bonus payments, a state (defined as the 50 states and the District of Columbia) would (1) have lower than expected aggregate medical assistance expenditures excluding expenditures for other non-elderly, nondisabled, non-expansion adults for that fiscal year and (2) have to submit the required information to the HHS Secretary.

For the Medicaid and CHIP quality performance bonus payments, lower than expected aggregate medical assistance expenditures would be the amounts (if any) by which the *adjusted total medical assistance expenditures* defined in Section 133 of the draft bill (i.e., actual medical assistance expenditures minus the excluded expenditures and the excluded populations) excluding expenditures for other non-elderly, nondisabled, non-expansion adults are less than the *target total medical assistance expenditures* as defined in Section 133 of the draft bill (i.e., the targeted medical assistance expenditures under the per capita allotment) excluding expenditures for other non-elderly, nondisabled, non-expansion adults.

To be eligible for the bonus payments, states would be required to submit to the following information: (1) quality measures for each category of Medicaid eligible individuals and (2) a plan for spending a portion of the bonus payment funds on quality improvement. The quality measures states would be required to submit for the bonus payments would be determined by the HHS Secretary and may include, among other measures, those identified under SSA Sections 1139A and 1139B.

The bonus payment allotments for states would be determined according to a formula established by the HHS Secretary. The formula would be based on performance, including improvement, with respect to the quality measures (as determined by the HHS Secretary) for Medicaid and CHIP over the performance period (as determined by the HHS Secretary) for such fiscal year. The quality bonus payment allotments for all states would total \$8 billion for FY2023 through FY2026.

The quality bonus payment allotment funds would be used to increase the Medicaid federal matching rate of 50% for administrative services by such percentage (as determined by the HHS Secretary) so that the increase does not exceed each state's quality bonus payment allotment.

Section 135. Grandfathering Certain Medicaid Waivers; Prioritization of HCBS Waivers

Section 135(a)(1) would allow states that are operating *grandfathered managed care waivers* to elect, through a state plan amendment, to continue in perpetuity to implement the managed care delivery system that is the subject of the waiver, without submitting an application for a new waiver. The approval would be valid so long as the terms and conditions of the waiver involved (other than any terms and conditions relating to budget neutrality) are not modified. Section 135(a)(3) would define a *grandfathered managed care waiver* as a waiver or an experimental, pilot or demonstration project relating to a state's authority to implement a managed care delivery system, which (1) had been approved by the HHS Secretary under SSA Section 1915(b), SSA Section 1115(a)(1), or SSA Section 1932, as of January 1, 2017; and (2) has been renewed by the HHS Secretary at least once.

Under Section 135(a)(2), if a state operating a *grandfathered managed care waiver* seeks to modify the terms and conditions of the waiver, it would be required to do so by applying for approval of a new waiver under the modified terms and conditions. The application would be deemed approved unless the HHS Secretary responds to the state within 90 days with either a denial or a request for more information. If the Secretary requests additional information, the Secretary has 30 days after the state submission in response to the request to deny the application or request more information.

Section 135(b) would require the HHS Secretary to implement procedures encouraging states to adopt or extend waivers related to the authority of a state to make medical assistance available for home and

community-based services under the Medicaid state plan if the state determines that such waivers would improve patient access to services.

Section 136. Coordination with States

Section 136 would modify the SSA by adding a new Section 1904A that requires the HHS Secretary to undertake additional policy consultation with states and additional Medicaid rulemaking procedures, effective for rules that are finalized on or after January 1, 2018. The HHS Secretary would be required to solicit advice from Medicaid state agencies and state Medicaid Directors on a regular, ongoing basis on matters relating to the operation or financing of the Medicaid program. In addition, the HHS Secretary would be required to: (1) establish a process for soliciting input from Medicaid state agencies and state Medicaid Directors before the submission of any final proposed rule, plan amendment, waiver request, or project proposal that is likely to have a direct effect on the operation or financing of the Medicaid state plan (or Medicaid waiver); (2) accept and consider written and oral comments on the proposed rule both from a bipartisan, nonprofit, professional organization that represents state Medicaid directors, and from Medicaid state agencies; and (3) incorporate such comments (and the HHS Secretary response) in the preamble to the proposed rule.

Section 137. Optional Assistance for Certain Inpatient Psychiatric Services

Section 137(a). State Option to Provide Certain Inpatient Psychiatric Services

Section 137 would provide states with the option of providing Medicaid coverage of *qualified inpatient psychiatric hospital services* to individuals over the age of 21 and under the age of 65.

For this provision, qualified inpatient psychiatric hospital services would be services furnished at a psychiatric hospital (i.e., an institution that is primarily engaged in providing for the diagnosis and treatment of mentally ill persons) for a Medicaid enrollee who has a stay that does not exceed (1) 30 consecutive days in a month and (2) 90 days in any calendar year.

As a condition of providing this coverage, states would be required to maintain the number of licensed beds at psychiatric hospitals owned, operated, or contracted for by the state on the date of enactment of this provision unless the numbers of beds increases between the date of enactment and when the state applies to provide this coverage. In that case, the state would be required to maintain the number of beds as of the date of application.

As another condition of providing this coverage, states would be required to maintain the level of annual state spending for (1) inpatient services at a psychiatric hospital and (2) active psychiatric care and treatment provided on an outpatient basis as of the date of enactment of this provision unless the state spending on these services increases between the date of enactment and when the state applies to provide this coverage. In that case, the state would be required to maintain the annual state spending on inpatient and outpatient psychiatric care as of the date of application.

States would receive a 50% federal matching rate for providing coverage of qualified inpatient psychiatric hospital services to Medicaid enrollees over the age of 21 and under the age of 65.

This provision would be effective on or after October 1, 2018.

Section 137(b). Matching Rate for Coverage of Certain Inpatient Psychiatric Services

Section 137(b) would establish a special federal matching rate of 50% for providing coverage of qualified inpatient psychiatric hospital services to Medicaid enrollees over the age of 21 and under the age of 65 under the option in Section 137(a).

Section 138. Enhanced FMAP for Medical Assistance to Eligible Indians

Section 138 would modify SSA Section 1905(b) by providing for a 100% FMAP rate for amounts expended as medical assistance for services provided by any provider under a Medicaid state plan to an individual who is a member of an Indian tribe and eligible for assistance under a Medicaid state plan.

Section 139. Small Business Health Plans

Section 139 would add a new Part 8 to Subtitle B of Title I of ERISA and establish Small Business Health Plans (SBHPs). For purposes of regulation under the PHSa, ERISA, and IRC, SBHPs would be treated as group health plans.

New ERISA Section 801 would define an SBHP as a fully-insured group health plan offered by a large group insurer; therefore, an SBHP would be a group health plan authorized under ERISA that would be subject to existing federal requirements applicable to such plans. A sponsor of an SBHP would be required to receive certification from the Secretary of the Department of Labor (Labor Secretary); be organized and maintained in good faith, be a permanent entity, be established for a purpose other than providing health benefits (such as a bona fide trade association, franchise, or section 7705 organization), and not condition membership on a minimum group size.

New ERISA Section 802 would require the Labor Secretary to promulgate regulations regarding certification of SBHPs and qualified sponsors (including certification revocation) and oversight of certified sponsors. The section would establish standards related to the certification process and information to be submitted in the application for certification, and require an SBHP to pay a filing fee to the Labor Secretary for purposes of administering the certification process. If the Secretary did not make a determination with respect to a certification application within 90 days of receipt of such application, the applicable sponsor would be deemed certified, until the Secretary denies the application. The Secretary would be allowed to assess a penalty if the Secretary determined that the certification application was willfully or negligently incomplete or inaccurate.

New ERISA Section 803 would establish standards regarding employers' eligibility to participate in an SBHP. The section also identifies the types of individuals who would be allowed to have coverage under an SBHP; they include owners, officers, partners, employees, and the dependents of such individuals. With respect to coverage renewal requirements, a participating employer would not be deemed a plan sponsor. A participating employer would be prohibited from providing individual health insurance to an employee who was excluded from the SBHP due to health status. An SBHP would be required to provide information about all coverage options under the plan to any employer who is eligible to participate.

ERISA Section 804 would establish definitions applicable to the provisions under ERISA Part 8, including definitions related to franchises and section 7705 organizations. Most definitions refer to existing definitions in ERISA or PHSa. This section would preempt any and all state laws that would preclude an insurer from offering coverage in connection with an SBHP.

Section 139 would go into effect one year after enactment. The Labor Secretary would be required to promulgate all necessary regulations to implement the amendments proposed under Section 139 within six months of enactment.

Section 201. The Prevention and Public Health Fund

Section 201 would amend ACA Section 4002(b) by repealing all PPHF appropriations for FY2019 and subsequent fiscal years.

Section 202. Support for State Response to Opioid and Substance Abuse Crisis

Section 202 would authorize to be appropriated and would appropriate to the HHS Secretary (1) \$4,972,000,000 for each of FY2018 – FY2026 to provide grants to states to support substance use disorder treatment and recovery support services and (2) \$50,400,000 for each of FY2018 – FY2022 “for research on addiction and pain related to the substance abuse crisis.” Such funds would remain available until expended.

Section 203. Community Health Center Program

Section 203 would provide an additional \$422 million for FY2017 to the Community Health Center Fund.

Section 204. Change in Permissible Age Variation in Health Insurance Premium Rates

Section 204 would amend PHSA Section 2701(a)(1)(A)(iii) and establish an age rating ratio of 5:1 for adults for plan years beginning on or after January 1, 2019. That is, a plan would not be able to charge a 64-year-old individual more than five times the premium that the plan would charge a 21-year-old individual. States would have the option to implement a ratio for adults that is different from the 5:1 ratio.

Section 205. Medical Loss Ratio Determined by the State

Section 205 would amend PHSA Sections 2718(b) and 2718(d). Section 2718(b) spells out specific MLR ratios that individual, small group, and large group plans must meet; the calculation of enrollee rebates; and requires the HHS Secretary to promulgate regulations to enforce the provisions, including appropriate penalties. Section 205 would add new subsections (4) and (5). New subsection (4) would sunset these MLR requirements for plan years beginning on or after January 1, 2019. Section 205 further states that after that date, any reference in law to the MLR requirement would have no force or effect.

New subsection (5) would require states to set their own MLRs for group and individual coverage, starting with plan years beginning on or after January 1, 2019. States would set the ratio of premium revenue that plans may use for non-claims costs to the total amount of premium revenue and would determine the amount of any annual rebate required to enrollees if the ratio of the amount of premium revenue expended by the issuer on non-claims costs to the total amount of premium revenue exceeds the ratio set by the state.

Section 205 would sunset Section 2718(d) for plan years beginning on or after January 1, 2019. Section 2718(d) allows the HHS Secretary to adjust the MLR ratios described in Section 2718(b) if the Secretary determines such an adjustment to be appropriate on account of volatility of the individual market due to the establishment of health insurance exchanges.

Section 206. Stabilizing the Individual Insurance Markets

Section 206 would amend PHSA Section 2702(b) to renumber existing paragraph (3) as paragraph (4) and add a new paragraph (3). Under the new paragraph, issuers offering plans in the individual market on or after January 1, 2019 would be required to impose a 6 month waiting period on individuals who had a gap in *creditable coverage*; creditable coverage has the meaning given to the term as currently defined in PHSA Section 2704(c)(1), and includes membership in a health care sharing ministry, as defined in IRC Section 5000A(d)(2)(B). For an individual submitting an insurance application during an OEP, a significant break in coverage (a period of 63 days or longer) within a 12-month period would constitute a gap. For an individual submitting an application during a SEP, a gap consists of either a significant break in coverage within a 12-month period or no creditable coverage during the 60 days prior to submitting such application. Gaps related to waiting periods, as currently defined in subparagraphs (A) and (B) of PHSA Section 2704(c)(2), would not be included when assessing 12 months of continuous creditable coverage. Issuers would not be allowed to impose a waiting period on individuals who had individual

health insurance coverage the day before the effective date of the coverage in which they were newly enrolling; newborns who enroll in coverage within 30 days of the date of birth; adopted children (who were adopted or placed for adoption before turning age 18) who enroll in coverage within 30 days of the date of the adoption; and other individuals, as determined by the Secretary.

Coverage for an individual who qualifies to obtain coverage during an OEP or an SEP and is subject to a waiting period would begin on the first day of the first month that begins 6 months after the date on which the individual submits an application for coverage. Coverage for an individual who submits an application outside the OEP, does not qualify for an SEP, and is subject to a waiting period would begin the later of either (1) the first day of the first month that begins 6 months after the day on which the individual submits an application for coverage or (2) the first day of the following plan year.

The HHS Secretary would require issuers and health care sharing ministries to provide certification of periods of creditable coverage and waiting periods for purposes of verifying that the continuous coverage requirements are met.

Section 207. Waivers for State Innovation

Section 207 would not modify the specified provisions that can be waived under a 1332 waiver; however, in other sections of the legislation, the draft bill would alter three of the provisions that can be waived under a 1332 waiver: the individual mandate (Section 104), the employer mandate (Section 105), and the cost-sharing subsidies (Section 208).

Section 207(a)(2) would modify current law Section 1332(b)(1). It would amend the criteria—related to coverage, affordability, comprehensiveness, and federal-deficit neutrality—a state’s plan would have to meet in order for the Secretary to approve a 1332 waiver. Instead, the draft bill would require the Secretary to grant a state’s waiver request unless the Secretary determines that the state’s application has required elements that are missing, or the state’s plan would increase the federal deficit. The determination about whether the state’s plan increases the federal deficit would not take into account the new funding that would be made available under Section 207, as described in the following two paragraphs.

Section 207(a)(1)(B) would modify current law Section 1332(a)(3)—relating to pass through funding available to states under a 1332 waiver—to create three subsections, (A), (B), and (C). Subsection (A) would include the pass through funding text in current law Section 1332(a)(3), and it would include new text to allow a state to request that all, or a portion of, the aggregate pass through funding amounts determined by the Secretary be paid to the state. Under subsection (B), \$2 billion would be appropriated to the Secretary for FY2017 and remain available through FY2019 to provide grants to states for purposes of submitting an application for a 1332 waiver and implementing a state plan under a 1332 waiver.

Subsection (C) would allow a state to use funds received under the Long-Term State Stability and Innovation Program (as would be established in new SSA Section 2105(i) under Section 106 of the draft bill) to carry out the state plan under a 1332 waiver. A state would be allowed to do so as long as such use is consistent with specified requirements for funds received under the Long-Term State Stability and Innovation Program. The specified requirements with which the use would have to comply are in new SSA Section 2105(i)(1)—except (B)—and new SSA Section 2105(i)(7). (For more details about these requirements, see the summary of Section 106 in this memorandum.)

Section 207 would not otherwise modify current law Section 1332(a)(3) in a way that would limit the pass through funding available to a state. However, beginning in 2020 the draft bill would eliminate current law cost-sharing subsidies and small business health insurance tax credits, both of which are available as pass through funding under current law.

Section 207(a)(1)(A)(i) would modify Section 1332(a)(1)(B) relating to the information a state is required to include in its application for a 1332 waiver. An application would have to include a description of how the state's plan would, with respect to health insurance coverage, take the place of the waived provisions and provide for alternative means of, and requirements for, increasing access to comprehensive coverage, reducing average premiums, providing consumer choice in the purchase of health insurance, and increasing enrollment in private health insurance. An application also would have to include a 10-year budget plan that demonstrates that the state plan does not increase the federal deficit. (While a state would be required to include all of this information in its application for a waiver, as discussed above, the only criterion upon which the Secretary would be able to deny a waiver application is if the state's plan would increase the federal deficit.)

Per Section 207(a)(1)(A)(ii), the application could provide information about the state law that allows the state to carry out the actions under the waiver or include information about the certificate in effect. Per Section 207(a)(1)(B)(ii), the certificate is a document signed by the state's governor and state insurance commissioner that provides authority for the state's actions under the waiver.

Section 207(a)(1)(C) would modify Section 1332(a)(4) to require that the Secretary establish an expedited application and approval process that may be used if the Secretary determines that doing so is necessary to respond to an urgent or emergency situation related to health insurance coverage within a state.

Section 207(a)(3) would modify Section 1332(d)(2)(B) to provide that in the event the Secretary determines that a waiver should not be granted to an applicant, the Secretary must provide data for the basis of the determination to the state and appropriate committees of Congress. This would be in addition to the current law requirement to notify them about the determination and provide reasons for the determination.

Section 207(a)(4) would modify Section 1332(e) to provide that a 1332 waiver is in effect for a period of 8 years unless a state requests a shorter duration. A state could apply to renew the waiver for unlimited additional 8-year periods, and the waiver could not be canceled by the Secretary before the expiration of any 8-year period (including a renewal period).

Section 207(b) would address the applicability of Section 1332. In the case of a state that was granted a 1332 waiver prior to the date of enactment of the draft bill, section 1332, as in effect on the day before the date of enactment of the draft bill, would apply to the waiver and the state plan. In the case of a state that submitted an application for a 1332 waiver prior to the date of enactment but has not yet received approval, the state would be able to choose whether to have current law Section 1332 apply or the amended Section 1332 apply. For states that submit applications after the date of enactment, the amended Section 1332 would apply.

Section 208. Allowing All Individuals Purchasing Health Insurance in the Individual Market the Option to Purchase a Lower Premium Catastrophic Plan

Section 208 would amend ACA Section 1302(e) to allow any individual to enroll in a catastrophic plan, effective plan years beginning on or after January 1, 2019.

Section 208 would amend ACA Section 1312(c) to include enrollees in catastrophic plans as part of the individual market and small-group market's single risk pools for plan years beginning on or after January 1, 2019.

Section 102 would allow an individual who is eligible for the tax credit, as modified under Section 102, to apply that credit towards the purchase of a catastrophic plan.

Section 209. Application of Enforcement Penalties

Section 209 would amend Section 2723 of the PHSA to establish a penalty for violations of the ACA's abortion funding segregation requirements. A plan issuer that fails to comply with these requirements would be liable for a penalty of up to \$100 for each day for each individual with respect to whom such a failure occurs. In determining the actual amount of a penalty, the HHS Secretary would consider a plan issuer's previous record of compliance and the gravity of the violation.

Section 209 also would provide that a state's receipt of an ACA Section 1332 waiver shall not affect the HHS Secretary's authority to impose penalties under PHSA Section 2723.

Section 210. Funding for Cost-Sharing Payments

Section 210 would appropriate to the HHS Secretary such sums as may be necessary for cost-sharing subsidies (including adjustments to prior obligations for such payments) for the period beginning the date of enactment through December 31, 2019. Payments incurred and other actions for adjustments to obligations for plan years 2018 and 2019 could be available through December 31, 2020.

Section 211. Repeal of Cost-Sharing Subsidy Program

Section 211 would repeal ACA Section 1402, terminating the cost-sharing subsidies (and payments to issuers for such reductions), effective for plan years beginning in 2020.