

AMENDMENT NO. \_\_\_\_\_ Calendar No. \_\_\_\_\_

Purpose: In the nature of a substitute.

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

**H. R. 1628**

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

Referred to the Committee on \_\_\_\_\_ and  
ordered to be printed

Ordered to lie on the table and to be printed

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

Viz:

1 Strike all after the enacting clause and insert the fol-  
2 lowing:

3 **SECTION 1. SHORT TITLE.**

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

6 **TITLE I**

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

8 **EXCESS ADVANCE PAYMENTS OF PREMIUM**

9 **TAX CREDITS.**

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

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

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

6       (a) **ELIGIBILITY FOR CREDIT.**—

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

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

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

16       (2) **TREATMENT OF CERTAIN ALIENS.**—

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

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

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

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

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

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

1 Opportunity Reconciliation Act of  
2 1996”, and

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

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

9 (1) USE OF BENCHMARK PLAN.—Section  
10 36B(b) of the Internal Revenue Code of 1986 is  
11 amended—

12 (A) by striking “applicable second lowest  
13 cost silver plan” each place it appears in para-  
14 graph (2)(B)(i) and (3)(C) and inserting “ap-  
15 plicable median cost benchmark plan”,

16 (B) by striking “such silver plan” in para-  
17 graph (3)(C) and inserting “such benchmark  
18 plan”, and

19 (C) in paragraph (3)(B)—

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

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

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

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

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

## 6

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

4 (A) in clause (i), by striking “from the ini-  
 5 tial premium percentage” and all that follows  
 6 and inserting “from the initial percentage to  
 7 the final percentage specified in such table for  
 8 such income tier with respect to a taxpayer of  
 9 the age involved:

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

10 (B) by striking “0.504” in clause (ii)(III)  
 11 and inserting “0.4”, and

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

14 “(iii) AGE DETERMINATIONS.—For  
 15 purposes of clause (i), the age of the tax-  
 16 payer taken into account under clause (i)  
 17 with respect to any taxable year is the age  
 18 attained before the close of the taxable  
 19 year by the oldest individual taken into ac-

1 count on such taxpayer's return who is  
2 covered by a qualified health plan taken  
3 into account under paragraph (2)(A).”.

4 (c) ELIMINATION OF ELIGIBILITY EXCEPTIONS FOR  
5 EMPLOYER-SPONSORED COVERAGE.—

6 (1) IN GENERAL.—Section 36B(c)(2) of the In-  
7 ternal Revenue Code of 1986 is amended by striking  
8 subparagraph (C).

9 (2) AMENDMENTS RELATED TO QUALIFIED  
10 SMALL EMPLOYER HEALTH REIMBURSEMENT AR-  
11 RANGEMENTS.—Section 36B(c)(4) of such Code is  
12 amended—

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

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

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

20 (1) IN GENERAL.—Section 36B(c)(3)(A) of the  
21 Internal Revenue Code of 1986 is amended by in-  
22 sserting at the end the following new sentence: “Such  
23 term shall not include a plan that includes coverage  
24 for abortions (other than any abortion necessary to  
25 save the life of the mother or any abortion with re-

1 spect to a pregnancy that is the result of an act of  
2 rape or incest).”.

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

6 (e) ALLOWANCE OF CREDIT FOR CATASTROPHIC  
7 PLANS.—Section 36B(c)(3)(A) of the Internal Revenue  
8 Code of 1986, as amended by this Act, is amended by  
9 striking “, except that such term shall not include a quali-  
10 fied health plan that is a catastrophic plan described in  
11 section 1302(e) of such Act”.

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

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

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

22 **IT.**

23 (a) SUNSET.—

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

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

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

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

13           (1) IN GENERAL.—Subsection (h) of section  
14           45R of the Internal Revenue Code of 1986 is  
15           amended—

16           (A) by striking “Any term” and inserting  
17           the following:

18           “(1) IN GENERAL.—Any term”, and

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

21           “(2) EXCLUSION OF CERTAIN HEALTH  
22           PLANS.—The term ‘qualified health plan’ does not  
23           include any health plan that includes coverage for  
24           abortions (other than any abortion necessary to save  
25           the life of the mother or any abortion with respect

1 to a pregnancy that is the result of an act of rape  
2 or incest).”.

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

6 **SEC. 104. INDIVIDUAL MANDATE.**

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

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

11 (2) in paragraph (3)—

12 (A) by striking “\$695” in subparagraph

13 (A) and inserting “\$0”, and

14 (B) by striking subparagraph (D).

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

18 **SEC. 105. EMPLOYER MANDATE.**

19 (a) IN GENERAL.—

20 (1) Paragraph (1) of section 4980H(c) of the  
21 Internal Revenue Code of 1986 is amended by in-  
22 serting “(\$0 in the case of months beginning after  
23 December 31, 2015)” after “\$2,000”.

24 (2) Paragraph (1) of section 4980H(b) of the  
25 Internal Revenue Code of 1986 is amended by in-

1       serting “(\$0 in the case of months beginning after  
2       December 31, 2015)” after “\$3,000”.

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

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

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

10       “(h) SHORT-TERM ASSISTANCE TO ADDRESS COV-  
11 ERAGE AND ACCESS DISRUPTION AND PROVIDE SUPPORT  
12 FOR STATES.—

13               “(1) APPROPRIATION.—There are authorized to  
14 be appropriated, and are appropriated, out of monies  
15 in the Treasury not otherwise obligated,  
16 \$15,000,000,000 for each of calendar years 2018  
17 and 2019, and \$10,000,000,000 for each of calendar  
18 years 2020 and 2021, to the Administrator of the  
19 Centers for Medicare & Medicaid Services (in this  
20 subsection and subsection (i) referred to as the ‘Ad-  
21 ministrators’) to fund arrangements with health in-  
22 surance issuers to assist in the purchase of health  
23 benefits coverage by addressing coverage and access  
24 disruption and responding to urgent health care

1 needs within States. Funds appropriated under this  
2 paragraph shall remain available until expended.

3 “(2) PARTICIPATION REQUIREMENTS.—

4 “(A) GUIDANCE.—Not later than 30 days  
5 after the date of enactment of this subsection,  
6 the Administrator shall issue guidance to health  
7 insurance issuers regarding how to submit a no-  
8 tice of intent to participate in the program es-  
9 tablished under this subsection.

10 “(B) NOTICE OF INTENT TO PARTICI-  
11 PATE.—To be eligible for funding under this  
12 subsection, a health insurance issuer shall sub-  
13 mit to the Administrator a notice of intent to  
14 participate at such time (but, in the case of  
15 funding for calendar year 2018, not later than  
16 35 days after the date of enactment of this sub-  
17 section and, in the case of funding for calendar  
18 year 2019, 2020, or 2021, not later than March  
19 31 of the previous year) and in such form and  
20 manner as specified by the Administrator and  
21 containing—

22 “(i) a certification that the health in-  
23 surance issuer will use the funds in accord-  
24 ance with the requirements of paragraph  
25 (5); and

1                   “(ii) such information as the Adminis-  
2                   trator may require to carry out this sub-  
3                   section.

4                   “(3) PROCEDURE FOR DISTRIBUTION OF  
5                   FUNDS.—The Administrator shall determine an ap-  
6                   propriate procedure for providing and distributing  
7                   funds under this subsection that includes reserving  
8                   an amount equal to 1 percent of the amount appro-  
9                   priated under paragraph (1) for a calendar year for  
10                  providing and distributing funds to health insurance  
11                  issuers in States where the cost of insurance pre-  
12                  miums are at least 75 percent higher than the na-  
13                  tional average.

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

19                  “(5) USE OF FUNDS.—Funds provided to a  
20                  health insurance issuer under paragraph (1) shall be  
21                  subject to the requirements of paragraphs (1)(D)  
22                  and (7) of subsection (i) in the same manner as  
23                  such requirements apply to States receiving pay-  
24                  ments under subsection (i) and shall be used only

1 for the activities specified in paragraph (1)(A)(ii) of  
2 subsection (i).

3 “(i) LONG-TERM STATE STABILITY AND INNOVATION  
4 PROGRAM.—

5 “(1) APPLICATION AND CERTIFICATION RE-  
6 QUIREMENTS.—To be eligible for an allotment of  
7 funds under this subsection, a State shall submit to  
8 the Administrator an application, not later than  
9 March 31, 2018, in the case of allotments for cal-  
10 endar year 2019, and not later than March 31 of  
11 the previous year, in the case of allotments for any  
12 subsequent calendar year) and in such form and  
13 manner as specified by the Administrator, that con-  
14 tains the following:

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

17 “(i) To establish or maintain a pro-  
18 gram or mechanism to help high-risk indi-  
19 viduals in the purchase of health benefits  
20 coverage, including by reducing premium  
21 costs for such individuals, who have or are  
22 projected to have a high rate of utilization  
23 of health services, as measured by cost,  
24 and who do not have access to health in-  
25 surance coverage offered through an em-

1           ployer, enroll in health insurance coverage  
2           under a plan offered in the individual mar-  
3           ket (within the meaning of section  
4           5000A(f)(1)(C) of the Internal Revenue  
5           Code of 1986).

6           “(ii) To establish or maintain a pro-  
7           gram to enter into arrangements with  
8           health insurance issuers to assist in the  
9           purchase of health benefits coverage by  
10          stabilizing premiums and promoting State  
11          health insurance market participation and  
12          choice in plans offered in the individual  
13          market (within the meaning of section  
14          5000A(f)(1)(C) of the Internal Revenue  
15          Code of 1986).

16          “(iii) To provide payments for health  
17          care providers for the provision of health  
18          care services, as specified by the Adminis-  
19          trator.

20          “(iv) To provide health insurance cov-  
21          erage by funding assistance to reduce out-  
22          of-pocket costs, such as copayments, coin-  
23          surance, and deductibles, of individuals en-  
24          rolled in plans offered in the individual  
25          market (within the meaning of section

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

3                   “(B) A certification that the State shall  
4                   make, from non-Federal funds, expenditures for  
5                   1 or more of the activities specified in subpara-  
6                   graph (A) in an amount that is not less than  
7                   the State percentage required for the year  
8                   under paragraph (5)(B)(ii).

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

12                  “(D) A certification that none of the funds  
13                  provided under this subsection shall be used by  
14                  the State for an expenditure that is attributable  
15                  to an intergovernmental transfer, certified pub-  
16                  lic expenditure, or any other expenditure to fi-  
17                  nance the non-Federal share of expenditures re-  
18                  quired under any provision of law, including  
19                  under the State plans established under this  
20                  title and title XIX or under a waiver of such  
21                  plans.

22                  “(E) Such other information as necessary  
23                  for the Administrator to carry out this sub-  
24                  section.

1           “(2) ELIGIBILITY.—Only the 50 States and the  
2 District of Columbia shall be eligible for an allot-  
3 ment and payments under this subsection and all  
4 references in this subsection to a State shall be  
5 treated as only referring to the 50 States and the  
6 District of Columbia.

7           “(3) ONE-TIME APPLICATION.—If an applica-  
8 tion of a State submitted under this subsection is  
9 approved by the Administrator for a year, the appli-  
10 cation shall be deemed to be approved by the Admin-  
11 istrator for that year and each subsequent year  
12 through December 31, 2026.

13           “(4) LONG-TERM STATE STABILITY AND INNO-  
14 VATION ALLOTMENTS.—

15           “(A) APPROPRIATION; TOTAL ALLOT-  
16 MENT.—For the purpose of providing allot-  
17 ments to States under this subsection, there is  
18 appropriated, out of any money in the Treasury  
19 not otherwise appropriated—

20                   “(i) for calendar year 2019,  
21                   \$8,000,000,000;

22                   “(ii) for calendar year 2020,  
23                   \$14,000,000,000;

24                   “(iii) for calendar year 2021,  
25                   \$14,000,000,000;

1 “(iv) for calendar year 2022,  
2 \$19,200,000,000;

3 “(v) for calendar year 2023,  
4 \$19,200,000,000;

5 “(vi) for calendar year 2024,  
6 \$19,200,000,000;

7 “(vii) for calendar year 2025,  
8 \$19,200,000,000; and

9 “(viii) for calendar year 2026,  
10 \$19,200,000,000.

11 “(B) ALLOTMENTS.—

12 “(i) IN GENERAL.—In the case of a  
13 State with an application approved under  
14 this subsection with respect to a year, the  
15 Administrator shall allot to the State, in  
16 accordance with an allotment methodology  
17 specified by the Administrator that ensures  
18 that the spending requirement in para-  
19 graph (6) is met for the year and that re-  
20 serves an amount that is at least 1 percent  
21 of the amount appropriated under sub-  
22 paragraph (A) for a calendar year for al-  
23 lotments to each State where the cost of  
24 insurance premiums are at least 75 per-  
25 cent higher than the national average,

1 from amounts appropriated for such year  
2 under subparagraph (A), such amount as  
3 specified by the Administrator with respect  
4 to the State and application and year.

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

7 “(I) IN GENERAL.— In carrying  
8 out clause (i), with respect to a year  
9 (beginning with 2021), the Adminis-  
10 trator shall, not later than March 31  
11 of such year—

12 “(aa) determine the amount  
13 of funds, if any, remaining un-  
14 used under subparagraph (A)  
15 from the previous year; and

16 “(bb) if the Administrator  
17 determines that any funds so re-  
18 main from the previous year, re-  
19 distribute such remaining funds  
20 in accordance with an allotment  
21 methodology specified by the Ad-  
22 ministrator to States that have  
23 submitted an application ap-  
24 proved under this subsection for  
25 the year.

1                   “(II) APPLICABLE STATE PER-  
2                   CENTAGE.—The State percentage  
3                   specified for a year in paragraph  
4                   (5)(B)(ii) shall apply to funds redis-  
5                   tributed under subclause (I) in that  
6                   year.

7                   “(C) AVAILABILITY OF ALLOTTED STATE  
8                   FUNDS.—

9                   “(i) IN GENERAL.—Amounts allotted  
10                  to a State pursuant to subparagraph (B)(i)  
11                  for a year shall remain available for ex-  
12                  penditure by the State through the end of  
13                  the second succeeding year.

14                  “(ii) AVAILABILITY OF AMOUNTS RE-  
15                  DISTRIBUTED.—Amounts redistributed to  
16                  a State under subparagraph (B)(ii) in a  
17                  year shall be available for expenditure by  
18                  the State through the end of the second  
19                  succeeding year.

20                  “(5) PAYMENTS.—

21                  “(A) ANNUAL PAYMENT OF ALLOT-  
22                  MENTS.—Subject to subparagraph (B), the Ad-  
23                  ministrators shall pay to each State that has an  
24                  application approved under this subsection for a  
25                  year, from the allotment determined under

1 paragraph (4)(B) for the State for the year, an  
2 amount equal to the Federal percentage of the  
3 State’s expenditures for the year.

4 “(B) STATE EXPENDITURES REQUIRED  
5 BEGINNING 2022.—For purposes of subpara-  
6 graph (A), the Federal percentage is equal to  
7 100 percent reduced by the State percentage  
8 for that year, and the State percentage is equal  
9 to—

10 “(i) in the case of calendar year 2019,  
11 0 percent;

12 “(ii) in the case of calendar year  
13 2020, 0 percent;

14 “(iii) in the case of calendar year  
15 2021, 0 percent;

16 “(iv) in the case of calendar year  
17 2022, 7 percent;

18 “(v) in the case of calendar year  
19 2023, 14 percent;

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

22 “(vii) in the case of calendar year  
23 2025, 28 percent; and

24 “(viii) in the case of calendar year  
25 2026, 35 percent.

1                   “(C) ADVANCE PAYMENT; RETROSPECTIVE  
2                   ADJUSTMENT.—

3                   “(i) IN GENERAL.—If the Adminis-  
4                   trator deems it appropriate, the Adminis-  
5                   trator shall make payments under this sub-  
6                   section for each year on the basis of ad-  
7                   vance estimates of expenditures submitted  
8                   by the State and such other investigation  
9                   as the Administrator shall find necessary,  
10                  and shall reduce or increase the payments  
11                  as necessary to adjust for any overpayment  
12                  or underpayment for prior years.

13                  “(ii) MISUSE OF FUNDS.—If the Ad-  
14                  ministrators determines that a State is not  
15                  using funds paid to the State under this  
16                  subsection in a manner consistent with the  
17                  description provided by the State in its ap-  
18                  plication approved under paragraph (1),  
19                  the Administrator may withhold payments,  
20                  reduce payments, or recover previous pay-  
21                  ments to the State under this subsection  
22                  as the Administrator deems appropriate.

23                  “(D) FLEXIBILITY IN SUBMITTAL OF  
24                  CLAIMS.—Nothing in this subsection shall be  
25                  construed as preventing a State from claiming

1 as expenditures in the year expenditures that  
2 were incurred in a previous year.

3 “(6) REQUIRED USE FOR PREMIUM STABILIZA-  
4 TION AND INCENTIVES FOR INDIVIDUAL MARKET  
5 PARTICIPATION.—In determining allotments for  
6 States under this subsection for each of calendar  
7 years 2019, 2020, and 2021, the Administrator shall  
8 ensure that at least \$5,000,000,000 of the amounts  
9 appropriated for each such year under paragraph  
10 (4)(A) are used by States for the purposes described  
11 in paragraph (1)(A)(ii) and in accordance with guid-  
12 ance issued by the Administrator not later than 30  
13 days after the date of enactment of this subsection  
14 that specifies the parameters for the use of funds for  
15 such purposes.

16 “(7) EXEMPTIONS.—Paragraphs (2), (3), (5),  
17 (6), (8), (10), and (11) of subsection (c) do not  
18 apply to payments under this subsection.”.

19 (b) OTHER TITLE XXI AMENDMENTS.—

20 (1) Section 2101 of such Act (42 U.S.C.  
21 1397aa) is amended—

22 (A) in subsection (a), in the matter pre-  
23 ceding paragraph (1), by striking “The pur-  
24 pose” and inserting “Except with respect to  
25 short-term assistance activities under section



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

4 **SEC. 108. REPEAL OF THE TAX ON EMPLOYEE HEALTH IN-**  
5 **SURANCE PREMIUMS AND HEALTH PLAN**  
6 **BENEFITS.**

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

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

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

18 **SEC. 109. REPEAL OF TAX ON OVER-THE-COUNTER MEDICA-**  
19 **TIONS.**

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

23 (b) ARCHER MSAs.—Subparagraph (A) of section  
24 220(d)(2) of the Internal Revenue Code of 1986 is amend-

1 ed by striking “Such term” and all that follows through  
2 the period.

3 (c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS  
4 AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Sec-  
5 tion 106 of the Internal Revenue Code of 1986 is amended  
6 by striking subsection (f).

7 (d) EFFECTIVE DATES.—

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

12 (2) REIMBURSEMENTS.—The amendment made  
13 by subsection (c) shall apply to expenses incurred  
14 with respect to taxable years beginning after Decem-  
15 ber 31, 2016.

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

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

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

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

1 **SEC. 111. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO**  
2 **FLEXIBLE SPENDING ACCOUNTS.**

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

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

8 **SEC. 112. REPEAL OF TAX ON PRESCRIPTION MEDICA-**  
9 **TIONS.**

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

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

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

17 Section 4191 of the Internal Revenue Code of 1986  
18 is amended by adding at the end the following new sub-  
19 section:

20 “(d) APPLICABILITY.—The tax imposed under sub-  
21 section (a) shall not apply to sales after December 31,  
22 2017.”.

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

24 Subsection (j) of section 9010 of the Patient Protec-  
25 tion and Affordable Care Act is amended by striking “,

1 and” at the end of paragraph (1) and all that follows  
2 through “2017”.

3 **SEC. 115. REPEAL OF ELIMINATION OF DEDUCTION FOR**  
4 **EXPENSES ALLOCABLE TO MEDICARE PART D**  
5 **SUBSIDY.**

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

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

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

16 (a) IN GENERAL.—Subsection (a) of section 213 of  
17 the Internal Revenue Code of 1986 is amended by striking  
18 “10 percent” and inserting “7.5 percent”.

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

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

23 (a) IN GENERAL.—The Internal Revenue Code of  
24 1986 is amended by striking chapter 49.

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

4 **SEC. 118. PURCHASE OF INSURANCE FROM HEALTH SAV-**  
5 **INGS ACCOUNT.**

6 (a) IN GENERAL.—Paragraph (2) of section 223(d)  
7 of the Internal Revenue Code of 1986, as amended by sec-  
8 tion 109(a), is amended—

9 (1) by striking “and any dependent (as defined  
10 in section 152, determined without regard to sub-  
11 sections (b)(1), (b)(2), and (d)(1)(B) thereof) of  
12 such individual” in subparagraph (A) and inserting  
13 “any dependent (as defined in section 152, deter-  
14 mined without regard to subsections (b)(1), (b)(2),  
15 and (d)(1)(B) thereof) of such individual, and any  
16 child (as defined in section 152(f)(1)) of such indi-  
17 vidual who has not attained the age of 27 before the  
18 end of such individual’s taxable year”,

19 (2) by striking subparagraph (B) and inserting  
20 the following:

21 “(B) HEALTH INSURANCE MAY NOT BE  
22 PURCHASED FROM ACCOUNT.—Except as pro-  
23 vided in subparagraph (C), subparagraph (A)  
24 shall not apply to any payment for insurance.”,  
25 and

1           (3) by striking “or” at the end of subparagraph  
2           (C)(iii), by striking the period at the end of subpara-  
3           graph (C)(iv) and inserting “, or”, and by adding at  
4           the end the following:

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

8                               “(I) any amount allowable as a  
9                               credit under section 36B for the tax-  
10                              able year with respect to such cov-  
11                              erage,

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

15                             “(III) any amount excludable  
16                             from gross income with respect to  
17                             such coverage under section 106 (in-  
18                             cluding by reason of section 125) or  
19                             402(l).”.

20           (b) **EFFECTIVE DATE.**—The amendments made by  
21 this section shall apply with respect to amounts paid for  
22 expenses incurred for, and distributions made for, cov-  
23 erage under a high deductible health plan beginning after  
24 December 31, 2017.

1 **SEC. 119. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAV-**  
2 **INGS ACCOUNT INCREASED TO AMOUNT OF**  
3 **DEDUCTIBLE AND OUT-OF-POCKET LIMITA-**  
4 **TION.**

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

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

12 (c) **COST-OF-LIVING ADJUSTMENT.**—Section  
13 223(g)(1) of such Code is amended—

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

16 (2) in subparagraph (B), by striking “deter-  
17 mined by” and all that follows through “‘calendar  
18 year 2003’.” and inserting “determined by sub-  
19 stituting ‘calendar year 2003’ for ‘calendar year  
20 1992’ in subparagraph (B) thereof.”.

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

1 **SEC. 120. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CON-**  
2 **TRIBUTIONS TO THE SAME HEALTH SAVINGS**  
3 **ACCOUNT.**

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

6 “(5) SPECIAL RULE FOR MARRIED INDIVIDUALS  
7 WITH FAMILY COVERAGE.—

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

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

22 “(ii) such limitation (after application  
23 of clause (i)) shall be reduced by the ag-  
24 gregate amount paid to Archer MSAs of  
25 such spouses for the taxable year, and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 (b) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

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

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

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

2 The Social Security Act is amended—

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

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

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

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

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

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

23 (A) in subsection (a)(10)(A)—

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

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

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

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

10 “(nn) EXPANSION ENROLLEES.—

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

13 “(A) who is under 65 years of age;

14 “(B) who is not pregnant;

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

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

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

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

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

9           (A) in subsection (y)(1)—

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

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

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

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

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

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

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

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

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

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

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

4 (B) in subsection (z)(2)—

5 (i) in subparagraph (A)—

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

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

18 (ii) in subparagraph (B)(ii)—

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

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

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

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

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

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

10 “(C) NON-EXPANSION STATES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 year, a State that is not an expansion  
2 State, except that, in the case of a  
3 State that provides eligibility under  
4 clause (i)(VIII), (ii)(XX), or  
5 (ii)(XXIII) of section 1902(a)(10)(A)  
6 for medical assistance under this title  
7 (or provides eligibility for individuals  
8 described in any of such clauses under  
9 a waiver of the State plan approved  
10 under section 1115) for any quarter  
11 occurring during the period that be-  
12 gins on October 1, 2017, and ends on  
13 December 31, 2020, the State shall be  
14 treated as a non-expansion State for  
15 purposes of clause (i) only for quar-  
16 ters beginning on or after the first  
17 day of the first month for which the  
18 State no longer provides such eligi-  
19 bility.”.

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

21 (a) IN GENERAL.—

22 (1) STATE PLAN REQUIREMENTS.—Section  
23 1902(a)(34) of the Social Security Act (42 U.S.C.  
24 1396a(a)(34)) is amended by striking “in or after  
25 the third month” and all that follows through “indi-

1       vidual)” and inserting “in or after the month in  
2       which the individual (or, in the case of a deceased  
3       individual, another individual acting on the individ-  
4       ual’s behalf) made application (or, in the case of an  
5       individual who is 65 years of age or older or who is  
6       eligible for medical assistance under the plan on the  
7       basis of being blind or disabled, in or after the third  
8       month before such month)”.

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

22       (b) EFFECTIVE DATE.—The amendments made by  
23       subsection (a) shall apply to medical assistance with re-  
24       spect to individuals whose eligibility for such assistance

1 is based on an application for such assistance made (or  
2 deemed to be made) on or after October 1, 2017.

3 **SEC. 128. PROVIDING SAFETY NET FUNDING FOR NON-EX-**  
4 **PANSION STATES.**

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

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

10 “SEC. 1923A. (a) IN GENERAL.—Subject to the limi-  
11 tations of this section, for each year during the period be-  
12 ginning with fiscal year 2018 and ending with fiscal year  
13 2022, each State that is one of the 50 States or the Dis-  
14 trict of Columbia and that, as of July 1 of the preceding  
15 fiscal year, did not provide for eligibility under clause  
16 (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) for medical  
17 assistance under this title (or a waiver of the State plan  
18 approved under section 1115) (each such State or District  
19 referred to in this section for the fiscal year as a ‘non-  
20 expansion State’) may adjust the payment amounts other-  
21 wise provided under the State plan under this title (or a  
22 waiver of such plan) to health care providers that provide  
23 health care services to individuals enrolled under this title  
24 (in this section referred to as ‘eligible providers’) so long  
25 as the payment adjustment to such an eligible provider  
26 does not exceed the provider’s costs in furnishing health

1 care services (as determined by the Secretary and net of  
2 payments under this title, other than under this section,  
3 and by uninsured patients) to individuals who either are  
4 eligible for medical assistance under the State plan (or  
5 under a waiver of such plan) or have no health insurance  
6 or health plan coverage for such services.

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

13 “(1) 100 percent for calendar quarters in fiscal  
14 years 2018, 2019, 2020, and 2021; and

15 “(2) 95 percent for calendar quarters in fiscal  
16 year 2022.

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

23 “(1) the population of the State with income  
24 below 138 percent of the poverty line in 2015 (as de-  
25 termined based the table entitled ‘Health Insurance

1 Coverage Status and Type by Ratio of Income to  
2 Poverty Level in the Past 12 Months by Age’ for the  
3 universe of the civilian noninstitutionalized popu-  
4 lation for whom poverty status is determined based  
5 on the 2015 American Community Survey 1–Year  
6 Estimates, as published by the Bureau of the Cen-  
7 sus), to

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

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

16 **SEC. 129. ELIGIBILITY REDETERMINATIONS.**

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

21 “(J) FREQUENCY OF ELIGIBILITY REDE-  
22 TERMINATIONS.—Beginning on October 1,  
23 2017, and notwithstanding subparagraph (H),  
24 in the case of an individual whose eligibility for  
25 medical assistance under the State plan under

1           this title (or a waiver of such plan) is deter-  
2           mined based on the application of modified ad-  
3           justed gross income under subparagraph (A)  
4           and who is so eligible on the basis of clause  
5           (i)(VIII), (ii)(XX), or (ii)(XXIII) of subsection  
6           (a)(10)(A), at the option of the State, the State  
7           plan may provide that the individual’s eligibility  
8           shall be redetermined every 6 months (or such  
9           shorter number of months as the State may  
10          elect).”.

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

1 6-month or shorter basis) (as added by subsection (a)) to  
2 increase the frequency of eligibility redeterminations.

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

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

10 “(oo) OPTIONAL WORK REQUIREMENT FOR NON-  
11 DISABLED, NONELDERLY, NONPREGNANT INDIVID-  
12 UALS.—

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

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

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

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

8                   “(B) an individual who is under 19 years  
9                   of age;

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

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

18                           “(i) maintains satisfactory attendance  
19                           at secondary school or the equivalent; or

20                           “(ii) participates in education directly  
21                           related to employment.”.

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

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

11 **SEC. 131. PROVIDER TAXES.**

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

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

21   “(I) for fiscal year 2021, ‘5.8  
22 percent’ shall be substituted for ‘6  
23 percent’ each place it appears;

55

1 “(II) for fiscal year 2022, ‘5.6  
2 percent’ shall be substituted for ‘6  
3 percent’ each place it appears;

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

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

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

14 **SEC. 132. PER CAPITA ALLOTMENT FOR MEDICAL ASSIST-**  
15 **ANCE.**

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

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

19 (A) in subsection (a), in the matter before  
20 paragraph (1), by inserting “and section  
21 1903A(a)” after “except as otherwise provided  
22 in this section”; and

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

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

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

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

7           “(1) IN GENERAL.—If a State which is one of  
8           the 50 States or the District of Columbia has excess  
9           aggregate medical assistance expenditures (as de-  
10          fined in paragraph (2)) for a fiscal year (beginning  
11          with fiscal year 2020), the amount of payment to  
12          the State under section 1903(a)(1) for each quarter  
13          in the following fiscal year shall be reduced by  $\frac{1}{4}$  of  
14          the excess aggregate medical assistance payments  
15          (as defined in paragraph (3)) for that previous fiscal  
16          year. In this section, the term ‘State’ means only the  
17          50 States and the District of Columbia.

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

23                       “(A) the amount of the adjusted total med-  
24                       ical assistance expenditures (as defined in sub-

1 section (b)(1)) for the State and fiscal year; ex-  
2 ceeds

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

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

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

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

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

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

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

3           “(5) PER CAPITA BASE PERIOD.—

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

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

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

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

23           “(ii) shall not select any period of 8  
24 (or, in the case of a State selecting a base  
25 period under subparagraph (D), not less

1 than 4) consecutive fiscal quarters that be-  
2 gins with a fiscal quarter earlier than the  
3 first quarter of fiscal year 2014 or ends  
4 with a fiscal quarter later than the third  
5 fiscal quarter of 2017.

6 “(D) BASE PERIOD FOR LATE-EXPANDING  
7 STATES.—

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

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

1 requirements of this paragraph shall apply  
2 to a per capita base period selected under  
3 this subparagraph.

4 “(iii) APPLICATION OF BASE PERIOD  
5 ADJUSTMENTS.—The adjustments to  
6 amounts for per capita base periods re-  
7 quired under subsections (b)(5) and  
8 (d)(4)(E) shall be applied to amounts for  
9 per capita base periods selected under this  
10 subparagraph by substituting ‘divided by  
11 the ratio that the number of quarters in  
12 the base period bears to 4’ for ‘divided by  
13 2’.

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

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

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

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

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

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

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

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

17 “(2) MEDICAL ASSISTANCE EXPENDITURES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16                   “(A) for fiscal years before 2025—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 “(ii) are less than the mean per capita  
6 categorical medical assistance expenditures  
7 for the category for all States for such pre-  
8 ceding year by not less than 25 percent,  
9 the State’s target per capita medical as-  
10 sistance expenditures for such category for  
11 the fiscal year involved shall be increased  
12 by a percentage that shall be determined  
13 by the Secretary but which shall not be  
14 less than 0.5 percent or greater than 2  
15 percent.

16 “(C) RULES OF APPLICATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3               “(A) the product of—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 “(E) BLIND AND DISABLED CHILDREN.—

13 An individual who—

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

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

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

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

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

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

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

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

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

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

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

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

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

12 “(f) SPECIAL PAYMENT RULES.—

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

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

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

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

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

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

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

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

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

1 “(1) REPORTING OF CMS-64 DATA.—

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

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

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

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

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

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

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

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

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

25 “(III) either—

1                   “(aa) requires intensive  
2                   healthcare interventions (such as  
3                   multiple medications, therapies,  
4                   or durable medical equipment)  
5                   and intensive care coordination to  
6                   optimize health and avoid hos-  
7                   pitalizations or emergency de-  
8                   partment visits; or  
9                   “(bb) meets the criteria for  
10                   medical complexity under existing  
11                   risk adjustment methodologies  
12                   using a recognized, publicly avail-  
13                   able pediatric grouping system  
14                   (such as the pediatric complex  
15                   conditions classification system  
16                   or the Pediatric Medical Com-  
17                   plexity Algorithm) selected by the  
18                   Secretary in close collaboration  
19                   with the State agencies respon-  
20                   sible for administering State  
21                   plans under this title and a na-  
22                   tional panel of pediatric, pedi-  
23                   atric specialty, and pediatric sub-  
24                   specialty experts.

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

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

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

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

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

7           and

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

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

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

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

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

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

14 “(2) SELECTION OF ELIGIBLE STATES.—

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

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



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

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

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

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

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

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

15 “(5) REPORTING AND EVALUATION.—

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

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

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

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

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

10           “(ii) has in effect—

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

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

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

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

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

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

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

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

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

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

15 “(b) STATE APPLICATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21           “(II) birth certificate data; and

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

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

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

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

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

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

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

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

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

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

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

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

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

16           “(5) TIMELINE FOR SUBMISSION.—

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

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

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

6 “(c) FINANCING.—

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

13 “(2) AMOUNT OF BLOCK GRANT FUNDS.—

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

21 “(B) ENROLLEE CATEGORY AMOUNTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 “(3) FEDERAL PAYMENT AND STATE MAINTEN-  
19 NANCE OF EFFORT.—

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

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

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

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

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

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

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

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

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

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

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

3 “(D) REDUCTION FOR NONCOMPLIANCE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24          “(d) PROGRAM REQUIREMENTS.—

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

5           “(2) TERM OF PROGRAM.—

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

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

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

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

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

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

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

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

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

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

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

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

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

3 “(B) CONDITIONS FOR ELIGIBILITY.—

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

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

21 “(4) BENEFITS AND SERVICES.—

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

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

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

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

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

9 “(iv) Physician services.

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

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

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

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

19 “(ix) Nurse midwife services.

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

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

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

1 “(xiii) Non-cosmetic dental services.

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

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

11 “(C) BENEFIT PACKAGES.—

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

1           “(ii) AMOUNT, DURATION, AND SCOPE  
2           OF BENEFITS.—Subject to clause (i), the  
3           State shall determine the amount, dura-  
4           tion, and scope with respect to services  
5           provided as targeted health assistance  
6           under a Medicaid Flexibility Program, in-  
7           cluding with respect to services that are re-  
8           quired to be provided to certain program  
9           enrollees under subparagraph (A) except  
10          as otherwise provided under such subpara-  
11          graph.

12          “(iii) MENTAL HEALTH AND SUB-  
13          STANCE USE DISORDER COVERAGE AND  
14          PARITY.—The targeted health assistance  
15          provided by a State to program enrollees  
16          under a Medicaid Flexibility Program shall  
17          include mental health services and sub-  
18          stance use disorder services and the finan-  
19          cial requirements and treatment limitations  
20          applicable to such services under the pro-  
21          gram shall comply with the requirements  
22          of section 2726 of the Public Health Serv-  
23          ice Act in the same manner as such re-  
24          quirements apply to a group health plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16          “(3) PROGRAM ENROLLEE.—

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

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

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

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

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

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

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

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

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

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

25 “(bb) QUALITY PERFORMANCE BONUS PAYMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 (a) **MANAGED CARE WAIVERS.**—

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

1 (2) MODIFICATIONS.—

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

8 (B) APPROVAL OF MODIFICATION.—

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

14 (I) a denial; or

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

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

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

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

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

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

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

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

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

1 “COORDINATION WITH STATES

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

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

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

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

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

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

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

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

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

11 (1) in subsection (a)—

12 (A) in paragraph (16)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 **SEC. 139. SMALL BUSINESS HEALTH PLANS.**

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

18 (1) as a group health plan (as defined in sec-  
19 tion 2791 of the Public Health Service Act (42  
20 U.S.C. 300gg–91)) for purposes of applying title  
21 XXVII of the Public Health Service Act (42 U.S.C.  
22 300gg et seq.) and title XXII of such Act (42  
23 U.S.C. 300bb-1);

24 (2) as a group health plan (as defined in sec-  
25 tion 5000(b)(1) of the Internal Revenue Code of

1 1986) for purposes of applying sections 4980B and  
2 5000 and chapter 100 of the Internal Revenue Code  
3 of 1986; and

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

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

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

15 **RISK SHARING POOLS**

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

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

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

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

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

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

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

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

12   **“SEC. 802. FILING FEE AND CERTIFICATION OF SMALL**  
13                           **BUSINESS HEALTH PLANS.**

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

21           “(b) CERTIFICATION.—

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

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

5           “(B) may provide for continued certifi-  
6           cation of small business health plans under this  
7           part;

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

13          “(D) shall conduct oversight of certified  
14          plan sponsors, including periodic review, and  
15          consistent with section 504, applying the re-  
16          quirements of sections 518, 519, and 520; and

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

22          “(2) INFORMATION TO BE INCLUDED IN APPLI-  
23          CATION FOR CERTIFICATION.—An application for  
24          certification under this part meets the requirements  
25          of this section only if it includes, in a manner and

1 form which shall be prescribed by the applicable au-  
2 thority by regulation, at least the following informa-  
3 tion:

4 “(A) Identifying information.

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

7 “(C) Bonding requirements.

8 “(D) Plan documents.

9 “(E) Agreements with service providers.

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

15 “(A) structure and requirements for  
16 boards of trustees or plan administrators;

17 “(B) notification of material changes; and

18 “(C) notification for voluntary termination.

19 “(c) FILING NOTICE OF CERTIFICATION WITH  
20 STATES.—A certification granted under this part to a  
21 small business health plan shall not be effective unless  
22 written notice of such certification is filed by the plan  
23 sponsor with the applicable State authority of each State  
24 in which the small business health plan operates.

25 “(d) EXPEDITED AND DEEMED CERTIFICATION.—

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

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

17 **“SEC. 803. PARTICIPATION AND COVERAGE REQUIRE-**  
18 **MENTS.**

19          “(a) COVERED EMPLOYERS AND INDIVIDUALS.—The  
20          requirements of this subsection are met with respect to  
21          a small business health plan if, under the terms of the  
22          plan—

23                 “(1) each participating employer must be—

24                         “(A) a member of the sponsor;

25                         “(B) the sponsor; or

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

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

14                 “(A) active or retired owners (including  
15                 self-employed individuals with or without em-  
16                 ployees), officers, directors, or employees of, or  
17                 partners in, participating employers; or

18                 “(B) the dependents of individuals de-  
19                 scribed in subparagraph (A).

20          “(b) PARTICIPATING EMPLOYERS.—In applying re-  
21          quirements relating to coverage renewal, a participating  
22          employer shall not be deemed to be a plan sponsor.

23          “(c) PROHIBITION OF DISCRIMINATION AGAINST EM-  
24          PLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—

1 The requirements of this subsection are met with respect  
2 to a small business health plan if—

3 “(1) under the terms of the plan, no partici-  
4 pating employer may provide health insurance cov-  
5 erage in the individual market for any employee not  
6 covered under the plan, if such exclusion of the em-  
7 ployee from coverage under the plan is based on a  
8 health status-related factor with respect to the em-  
9 ployee and such employee would, but for such exclu-  
10 sion on such basis, be eligible for coverage under the  
11 plan; and

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

15 **“SEC. 804. DEFINITIONS; RENEWAL.**

16 “For purposes of this part:

17 “(1) **AFFILIATED MEMBER.**—The term ‘affili-  
18 ated member’ means, in connection with a sponsor—

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

22 “(B) in the case of a sponsor with mem-  
23 bers which consist of associations, a person who  
24 is a member or employee of any such associa-

1           tion and elects an affiliated status with the  
2           sponsor.

3           “(2) APPLICABLE STATE AUTHORITY.—The  
4           term ‘applicable State authority’ means, with respect  
5           to a health insurance issuer in a State, the State in-  
6           surance commissioner or official or officials des-  
7           ignated by the State to enforce the requirements of  
8           title XXVII of the Public Health Service Act for the  
9           State involved with respect to such issuer.

10           “(3) FRANCHISOR; FRANCHISEE.—The terms  
11           ‘franchisor’ and ‘franchisee’ have the meanings given  
12           such terms for purposes of sections 436.2(a)  
13           through 436.2(c) of title 16, Code of Federal Regu-  
14           lations (including any such amendments to such regu-  
15           lation after the date of enactment of this part) and,  
16           for purposes of this part, franchisor or franchisee  
17           employers participating in such a group health plan  
18           shall not be treated as the employer, co-employer, or  
19           joint employer of the employees of another partici-  
20           pating franchisor or franchisee employer for any  
21           purpose.

22           “(4) HEALTH PLAN TERMS.—The terms ‘group  
23           health plan’, ‘health insurance coverage’, and ‘health  
24           insurance issuer’ have the meanings given such  
25           terms in section 733.

1 “(5) INDIVIDUAL MARKET.—

2 “(A) IN GENERAL.—The term ‘individual  
3 market’ means the market for health insurance  
4 coverage offered to individuals other than in  
5 connection with a group health plan.

6 “(B) TREATMENT OF VERY SMALL  
7 GROUPS.—

8 “(i) IN GENERAL.—Subject to clause  
9 (ii), such term includes coverage offered in  
10 connection with a group health plan that  
11 has fewer than 2 participants as current  
12 employees or participants described in sec-  
13 tion 732(d)(3) on the first day of the plan  
14 year.

15 “(ii) STATE EXCEPTION.—Clause (i)  
16 shall not apply in the case of health insur-  
17 ance coverage offered in a State if such  
18 State regulates the coverage described in  
19 such clause in the same manner and to the  
20 same extent as coverage in the small group  
21 market (as defined in section 2791(e)(5) of  
22 the Public Health Service Act) is regulated  
23 by such State.

24 “(6) PARTICIPATING EMPLOYER.—The term  
25 ‘participating employer’ means, in connection with a

1 small business health plan, any employer, if any in-  
2 dividual who is an employee of such employer, a  
3 partner in such employer, or a self-employed indi-  
4 vidual who is such employer with or without employ-  
5 ees (or any dependent, as defined under the terms  
6 of the plan, of such individual) is or was covered  
7 under such plan in connection with the status of  
8 such individual as such an employee, partner, or  
9 self-employed individual in relation to the plan.

10 “(7) SECTION 7705 ORGANIZATION.—The term  
11 ‘section 7705 organization’ means an organization  
12 providing services for a customer pursuant to a con-  
13 tract meeting the conditions of subparagraphs (A),  
14 (B), (C), (D), and (E) (but not (F)) of section  
15 7705(e)(2) of the Internal Revenue Code of 1986,  
16 including an entity that is part of a section 7705 or-  
17 ganization control group . For purposes of this part,  
18 any reference to ‘member’ shall include a customer  
19 of a section 7705 organization except with respect to  
20 references to a ‘member’ or ‘members’ in paragraph  
21 (1).”.

22 (c) PREEMPTION RULES.—Section 514 of the Em-  
23 ployee Retirement Income Security Act of 1974 (29  
24 U.S.C. 1144) is amended by adding at the end the fol-  
25 lowing:



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

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

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

7 There is authorized to be appropriated, and is appro-  
8 priated, to the Secretary of Health and Human Services,  
9 out of monies in the Treasury not otherwise obligated—

10 (1) \$4,972,000,000 for each of fiscal years  
11 2018 through 2026, to provide grants to States to  
12 support substance use disorder treatment and recov-  
13 ery support services for individuals who have or may  
14 have mental or substance use disorders, including  
15 counseling, medication assisted treatment, and other  
16 substance abuse treatment and recovery services as  
17 such Secretary determines appropriate; and

18 (2) \$50,400,000 for each of fiscal years 2018  
19 through 2022, for research on addiction and pain re-  
20 lated to the substance abuse crisis.

21 Funds appropriated under this section shall remain avail-  
22 able until expended.

23 **SEC. 203. COMMUNITY HEALTH CENTER PROGRAM.**

24 Effective as if included in the enactment of the Medi-  
25 care Access and CHIP Reauthorization Act of 2015 (Pub-

1 lie Law 114–10, 129 Stat. 87), paragraph (1) of section  
2 221(a) of such Act is amended by inserting “, and an ad-  
3 ditional \$422,000,000 for fiscal year 2017” after “2017”.

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

6 Section 2701(a)(1)(A)(iii) of the Public Health Serv-  
7 ice Act (42 U.S.C. 300gg(a)(1)(A)(iii)) is amended by in-  
8 serting after “(consistent with section 2707(c))” the fol-  
9 lowing: “or, for plan years beginning on or after January  
10 1, 2019, 5 to 1 for adults (consistent with section 2707(c))  
11 or such other ratio for adults (consistent with section  
12 2707(c)) as the State may determine”.

13 **SEC. 205. MEDICAL LOSS RATIO DETERMINED BY THE**  
14 **STATE.**

15 Section 2718(b) of the Public Health Service Act (42  
16 U.S.C. 300gg–18(b)) is amended by adding at the end the  
17 following:

18 “(4) SUNSET.—Paragraphs (1) through (3) and  
19 subsection (d) shall not apply for plan years begin-  
20 ning on or after January 1, 2019, and after such  
21 date any reference in law to such paragraphs and  
22 subsection shall have no force or effect.

23 “(5) MEDICAL LOSS RATIO DETERMINED BY  
24 THE STATE.—For plan years beginning on or after  
25 January 1, 2019, each State shall—

1           “(A) set the ratio of the amount of pre-  
2           mium revenue a health insurance issuer offering  
3           group or individual health insurance coverage  
4           may expend on non-claims costs to the total  
5           amount of premium revenue; and

6           “(B) determine the amount of any annual  
7           rebate required to be paid to enrollees under  
8           such coverage if the ratio of the amount of pre-  
9           mium revenue expended by the issuer on non-  
10          claims costs to the total amount of premium  
11          revenue exceeds the ratio set by the State under  
12          subparagraph (A).”.

13 **SEC. 206. STABILIZING THE INDIVIDUAL INSURANCE MAR-**  
14 **KETS.**

15       (a) **ENROLLMENT WAITING PERIODS.**—Section  
16 2702(b)(1) of the Public Health Services Act (42 U.S.C.  
17 300gg–1(b)(1)) is amended by inserting “, and as de-  
18 scribed in paragraph (3)” before the period.

19       (b) **CREDITABLE COVERAGE REQUIREMENT.**—Sec-  
20 tion 2702(b)(2) of the Public Health Services Act (42  
21 U.S.C. 300gg–1(b)(2)) is amended by striking “paragraph  
22 (3)” and inserting “paragraph (4)”.

23       (c) **APPLICATION OF WAITING PERIODS.**—Section  
24 2702(b) of the Public Health Services Act (42 U.S.C.  
25 300gg-1(b)) is amended—

1 (1) in paragraph (3)—

2 (A) by striking “with respect to enrollment  
3 periods under paragraphs (1) and (2)”, insert-  
4 ing “in accordance with this subsection”; and

5 (B) by redesignating such paragraph as  
6 paragraph (4); and

7 (2) by inserting after paragraph (2), the fol-  
8 lowing:

9 “(3) WAITING PERIODS.—

10 “(A) IN GENERAL.—With respect to health  
11 insurance coverage that is effective on or after  
12 January 1, 2019, a health insurance issuer de-  
13 scribed in subsection (a) that offers such cov-  
14 erage in the individual market shall impose a 6  
15 month waiting period (as defined in the same  
16 manner as such term is defined in section  
17 2704(b)(4) for group health plans) on any indi-  
18 vidual who enrolls in such coverage and who  
19 cannot demonstrate—

20 “(i) in the case of an individual sub-  
21 mitting an application during an open en-  
22 rollment period, 12 months of continuous  
23 creditable coverage without experiencing a  
24 significant break in such coverage as de-

1 scribed in subparagraphs (A) and (B) of  
2 section 2704(c)(2); or

3 “(ii) in the case of an individual sub-  
4 mitting an application during a special en-  
5 rollment period—

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

9 “(II) at least 1 day of creditable  
10 coverage during the 60-day period im-  
11 mediately preceding the date of sub-  
12 mission of such application.

13 “(B) INDIVIDUALS ENROLLED IN OTHER  
14 COVERAGE.—Such a waiting period shall not  
15 apply to an individual who is enrolled in health  
16 insurance coverage in the individual market on  
17 the day before the effective date of the coverage  
18 in which the individual is newly enrolling.

19 “(C) WAITING PERIOD DESCRIBED.—For  
20 purposes of subparagraph (A)—

21 “(i) in the case of an individual that  
22 submits an application during an open en-  
23 rollment period or under a special enroll-  
24 ment period for which the individual quali-  
25 fies, coverage under the plan begins on the

1 first day of the first month that begins 6  
2 months after the date on which the indi-  
3 vidual submits an application for health in-  
4 surance coverage; and

5 “(ii) in the case of an individual that  
6 submits an application outside of an open  
7 enrollment period and does not qualify for  
8 enrollment under a special enrollment pe-  
9 riod, coverage under the plan begins on the  
10 later of—

11 “(I) the first day of the first  
12 month that begins 6 months after the  
13 day on which the individual submits  
14 an application for health insurance  
15 coverage; or

16 “(II) the first day of the next  
17 plan year.

18 “(D) CERTIFICATES OF CREDITABLE COV-  
19 ERAGE.—The Secretary shall require health in-  
20 surance issuers and health care sharing min-  
21 istries (as defined in section 5000A(d)(2)(B) of  
22 the Internal Revenue Code of 1986) to provide  
23 certification of periods of creditable coverage  
24 and waiting periods, in a manner prescribed by  
25 the Secretary, for purposes of verifying that the

1 continuous coverage requirements of subpara-  
2 graph (A) are met.

3 “(E) CONTINUOUS CREDITABLE COVERAGE  
4 DEFINED.—For purposes of this paragraph, the  
5 term ‘creditable coverage’—

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

8 “(ii) includes membership in a health  
9 care sharing ministry (as defined in section  
10 5000A(d)(2)(B) of the Internal Revenue  
11 Code of 1986).

12 “(F) EXCEPTIONS.—Notwithstanding sub-  
13 paragraph (A), a health insurance issuer may  
14 not impose a waiting period with respect to the  
15 following individuals:

16 “(i) A newborn who is enrolled in  
17 such coverage within 30 days of the date  
18 of birth.

19 “(ii) A child who is adopted or placed  
20 for adoption before attaining 18 years of  
21 age and who is enrolled in such coverage  
22 within 30 days of the date of the adoption.

23 “(iii) Other individuals, as the Sec-  
24 retary determines appropriate.”.

1 **SEC. 207. WAIVERS FOR STATE INNOVATION.**

2 (a) IN GENERAL.—Section 1332 of the Patient Pro-  
3 tection and Affordable Care Act (42 U.S.C. 18052) is  
4 amended—

5 (1) in subsection (a)—

6 (A) in paragraph (1)—

7 (i) in subparagraph (B)—

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

10 “(i) a description of how the State  
11 plan meeting the requirements of a waiver  
12 under this section would, with respect to  
13 health insurance coverage within the  
14 State—

15 “(I) take the place of the require-  
16 ments described in paragraph (2) that  
17 are waived; and

18 “(II) provide for alternative  
19 means of, and requirements for, in-  
20 creasing access to comprehensive cov-  
21 erage, reducing average premiums,  
22 providing consumers the freedom to  
23 purchase the health insurance of their  
24 choice, and increasing enrollment in  
25 private health insurance; and”;

1 (II) in clause (ii), by striking  
2 “that is budget neutral for the Fed-  
3 eral Government” and inserting “,  
4 demonstrating that the State plan  
5 does not increase the Federal deficit”;  
6 and

7 (ii) in subparagraph (C), by striking  
8 “the law” and inserting “a law or has in  
9 effect a certification”;

10 (B) in paragraph (3)—

11 (i) in the first sentence, by inserting  
12 “or would qualify for a reduction in” after  
13 “would not qualify for”;

14 (ii) by adding after the second sen-  
15 tence the following: “A State may request  
16 that all of, or any portion of, such aggre-  
17 gate amount of such credits or reductions  
18 be paid to the State as described in the  
19 first sentence.”;

20 (iii) in the paragraph heading, by  
21 striking “PASS THROUGH OF FUNDING”  
22 and inserting “FUNDING”;

23 (iv) by striking “With respect” and  
24 inserting the following:

1           “(A) PASS THROUGH OF FUNDING.—With  
2           respect”; and

3                     (v) by adding at the end the following:

4           “(B) ADDITIONAL FUNDING.—There is au-  
5           thorized to be appropriated, and is appro-  
6           priated, to the Secretary of Health and Human  
7           Services, out of monies in the Treasury not oth-  
8           erwise obligated, \$2,000,000,000 for fiscal year  
9           2017, to remain available until the end of fiscal  
10          year 2019, to provide grants to States for pur-  
11          poses of submitting an application for a waiver  
12          granted under this section and implementing  
13          the State plan under such waiver.

14          “(C) AUTHORITY TO USE LONG-TERM  
15          STATE INNOVATION AND STABILITY ALLOT-  
16          MENT.—If the State has an application for an  
17          allotment under section 2105(i) of the Social  
18          Security Act for the plan year, the State may  
19          use the funds available under the State’s allot-  
20          ment for the plan year to carry out the State  
21          plan under this section, so long as such use is  
22          consistent with the requirements of paragraphs  
23          (1) and (7) of section 2105(i) of such Act  
24          (other than paragraph (1)(B) of such section).  
25          Any funds used to carry out a State plan under

1 this subparagraph shall not be considered in de-  
2 termining whether the State plan increases the  
3 Federal deficit.”; and

4 (C) in paragraph (4), by adding at the end  
5 the following:

6 “(D) EXPEDITED PROCESS.—The Sec-  
7 retary shall establish an expedited application  
8 and approval process that may be used if the  
9 Secretary determines that such expedited proc-  
10 ess is necessary to respond to an urgent or  
11 emergency situation with respect to health in-  
12 surance coverage within a State.”;

13 (2) in subsection (b)—

14 (A) in paragraph (1)—

15 (i) in the matter preceding subpara-  
16 graph (A)—

17 (I) by striking “may” and insert-  
18 ing “shall”; and

19 (II) by striking “only if” and in-  
20 serting “unless”; and

21 (ii) by striking “plan—” and all that  
22 follows through the period at the end of  
23 subparagraph (D) and inserting “applica-  
24 tion is missing a required element under  
25 subsection (a)(1) or that the State plan

1 will increase the Federal deficit, not taking  
2 into account any amounts received through  
3 a grant under subsection (a)(3)(B).”;

4 (B) in paragraph (2)—

5 (i) in the paragraph heading, by in-  
6 serting “OR CERTIFY” after “LAW”;

7 (ii) in subparagraph (A), by inserting  
8 before the period “, and a certification de-  
9 scribed in this paragraph is a document,  
10 signed by the Governor, and the State in-  
11 surance commissioner, of the State, that  
12 provides authority for State actions under  
13 a waiver under this section, including the  
14 implementation of the State plan under  
15 subsection (a)(1)(B)”;

16 (iii) in subparagraph (B)—

17 (I) in the subparagraph heading,  
18 by striking “OF OPT OUT”; and

19 (II) by striking “ may repeal a  
20 law” and all that follows through the  
21 period at the end and inserting the  
22 following: “may terminate the author-  
23 ity provided under the waiver with re-  
24 spect to the State by—

1 “(i) repealing a law described in sub-  
2 paragraph (A); or

3 “(ii) terminating a certification de-  
4 scribed in subparagraph (A), through a  
5 certification for such termination signed by  
6 the Governor, and the State insurance  
7 commissioner, of the State.”;

8 (3) in subsection (d)(2)(B), by striking “and  
9 the reasons therefore” and inserting “and the rea-  
10 sons therefore, and provide the data on which such  
11 determination was made”; and

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

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

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

20 “(3) may not be cancelled by the Secretary be-  
21 fore the expiration of the 8-year period (including  
22 any renewal period under paragraph (2)).”.

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

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

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

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

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

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

8 “(4) CONSUMER FREEDOM.—For plan years be-  
9 ginning on or after January 1, 2019, paragraph  
10 (1)(A) shall not apply with respect to any plan of-  
11 fered in the State.”.

12 (b) RISK POOLS.—Section 1312(e) of the Patient  
13 Protection and Affordable Care Act (42 U.S.C. 18032(e))  
14 is amended—

15 (1) in paragraph (1), by inserting “and includ-  
16 ing, with respect to plan years beginning on or after  
17 January 1, 2019, enrollees in catastrophic plans de-  
18 scribed in section 1302(e)” after “Exchange”; and

19 (2) in paragraph (2), by inserting “and includ-  
20 ing, with respect to plan years beginning on or after  
21 January 1, 2019, enrollees in catastrophic plans de-  
22 scribed in section 1302(e)” after “Exchange”.

23 **SEC. 209. APPLICATION OF ENFORCEMENT PENALTIES.**

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

26 (1) in subsection (a)—

1 (A) in paragraph (1), by inserting “and of  
2 section 1303 of the Patient Protection and Af-  
3 fordable Care Act” after “this part”; and

4 (B) in paragraph (2), by inserting “or in  
5 such section 1303” after “this part”; and

6 (2) in subsection (b)—

7 (A) in paragraphs (1) and (2)(A), by in-  
8 serting “or section 1303 of the Patient Protec-  
9 tion and Affordable Care Act” after “this part”  
10 each place such term appears;

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

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

19 **SEC. 210. FUNDING FOR COST-SHARING PAYMENTS.**

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

1 the period beginning on the date of enactment of this Act  
2 and ending on December 31, 2019. Notwithstanding any  
3 other provision of this Act, payments and other actions  
4 for adjustments to any obligations incurred for plan years  
5 2018 and 2019 may be made through December 31, 2020.

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

7 (a) **IN GENERAL.**—Section 1402 of the Patient Pro-  
8 tection and Affordable Care Act is repealed.

9 (b) **EFFECTIVE DATE.**—The repeal made by sub-  
10 section (a) shall apply to cost-sharing reductions (and pay-  
11 ments to issuers for such reductions) for plan years begin-  
12 ning after December 31, 2019.