

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

Purpose: In the nature of a substitute.

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

**H. R. 1628**

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

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

Ordered to lie on the table and to be printed

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

Viz:

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

3 **SECTION 1. SHORT TITLE.**

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

6 **TITLE I**

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

8 **EXCESS ADVANCE PAYMENTS OF PREMIUM**

9 **TAX CREDITS.**

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

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

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

6       (a) ELIGIBILITY FOR CREDIT.—

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

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

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

16       (2) TREATMENT OF CERTAIN ALIENS.—

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

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

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

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

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

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

1 Opportunity Reconciliation Act of  
2 1996”, and

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

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

9 (1) USE OF BENCHMARK PLAN.—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),

15 (B) by striking “the amount described in  
16 subparagraph (C)(i)(II) for such month” in  
17 subparagraph (B) and inserting “1/12 of the  
18 employee's permitted benefit (as defined in sec-  
19 tion 9831(d)(3)(C)) under such arrangement”,

20 (C) by striking subparagraphs (C) and (F)  
21 and redesignating subparagraphs (D) and (E)  
22 as subparagraphs (C) and (D), respectively, and

23 (D) in subparagraph (D), as so redesi-  
24 gnated, by striking “subparagraph (C)(i)(II)”  
25 and inserting “subparagraph (B)”.

1 (d) MODIFICATION OF DEFINITION OF QUALIFIED  
2 HEALTH PLAN.—

3 (1) IN GENERAL.—Section 36B(c)(3)(A) of the  
4 Internal Revenue Code of 1986 is amended by in-  
5 serting before the period at the end the following:  
6 “or a plan that includes coverage for abortions  
7 (other than any abortion necessary to save the life  
8 of the mother or any abortion with respect to a  
9 pregnancy that is the result of an act of rape or in-  
10 cest)”.

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

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

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

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

24 **IT.**

25 (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 IN-  
12          CLUDES COVERAGE FOR ABORTION.—

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 HEALTH PLANS INCLUDING  
22           COVERAGE FOR ABORTION.—The term ‘qualified  
23           health plan’ does not include any health plan that  
24           includes coverage for abortions (other than any  
25           abortion necessary to save the life of the mother or

1 any abortion with respect to a pregnancy that is the  
2 result of an act of rape 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 address coverage and access dis-  
23 ruption and respond to urgent health care needs  
24 within States. Funds appropriated under this para-  
25 graph shall remain available until expended.

1 “(2) PARTICIPATION REQUIREMENTS.—

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

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

20 “(i) a certification that the health in-  
21 surance issuer will use the funds in accord-  
22 ance with the requirements of paragraph  
23 (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.

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

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

21                  “(i) LONG-TERM STATE STABILITY AND INNOVATION  
22                  PROGRAM.—

23                  “(1) APPLICATION AND CERTIFICATION RE-  
24                  QUIREMENTS.—To be eligible for an allotment of  
25                  funds under this subsection, a State shall submit to

1 the Administrator an application, not later than  
2 March 31, 2018, in the case of allotments for cal-  
3 endar year 2019, and not later than March 31 of  
4 the previous year, in the case of allotments for any  
5 subsequent calendar year) and in such form and  
6 manner as specified by the Administrator, that con-  
7 tains the following:

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

10 “(i) To establish or maintain a pro-  
11 gram or mechanism to provide financial as-  
12 sistance to help high-risk individuals, in-  
13 cluding by reducing premium costs for  
14 such individuals, who have or are projected  
15 to have a high rate of utilization of health  
16 services, as measured by cost, and who do  
17 not have access to health insurance cov-  
18 erage offered through an employer, enroll  
19 in health insurance coverage under a plan  
20 offered in the individual market (within  
21 the meaning of section 5000A(f)(1)(C) of  
22 the Internal Revenue Code of 1986).

23 “(ii) To establish or maintain a pro-  
24 gram to enter into arrangements with  
25 health insurance issuers to help stabilize

1 premiums and promote State health insur-  
2 ance market participation and choice in  
3 plans offered in the individual market  
4 (within the meaning of section  
5 5000A(f)(1)(C) of the Internal Revenue  
6 Code of 1986).

7 “(iii) To provide payments for health  
8 care providers for the provision of health  
9 care services, as specified by the Adminis-  
10 trator.

11 “(iv) To provide assistance to reduce  
12 out-of-pocket costs, such as copayments,  
13 coinsurance, and deductibles, of individuals  
14 enrolled in plans offered in the individual  
15 market (within the meaning of section  
16 5000A(f)(1)(C) of the Internal Revenue  
17 Code of 1986).

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

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

4           “(D) A certification that none of the funds  
5           provided under this subsection shall be used by  
6           the State for an expenditure that is attributable  
7           to an intergovernmental transfer, certified pub-  
8           lic expenditure, or any other expenditure to fi-  
9           nance the non-Federal share of expenditures re-  
10          quired under any provision of law, including  
11          under the State plans established under this  
12          title and title XIX or under a waiver of such  
13          plans.

14          “(E) Such other information as necessary  
15          for the Administrator to carry out this sub-  
16          section.

17          “(2) ELIGIBILITY.—Only the 50 States and the  
18          District of Columbia shall be eligible for an allot-  
19          ment and payments under this subsection and all  
20          references in this subsection to a State shall be  
21          treated as only referring to the 50 States and the  
22          District of Columbia.

23          “(3) ONE-TIME APPLICATION.—If an applica-  
24          tion of a State submitted under this subsection is  
25          approved by the Administrator for a year, the appli-



1 cation shall be deemed to be approved by the Admin-  
2 istrator for that year and each subsequent year  
3 through December 31, 2026.

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

6 “(A) APPROPRIATION; TOTAL ALLOT-  
7 MENT.—For the purpose of providing allot-  
8 ments to States under this subsection, there is  
9 appropriated, out of any money in the Treasury  
10 not otherwise appropriated—

11 “(i) for calendar year 2019,  
12 \$8,000,000,000;

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

15 “(iii) for calendar year 2021,  
16 \$14,000,000,000;

17 “(iv) for calendar year 2022,  
18 \$6,000,000,000;

19 “(v) for calendar year 2023,  
20 \$6,000,000,000;

21 “(vi) for calendar year 2024,  
22 \$5,000,000,000;

23 “(vii) for calendar year 2025,  
24 \$5,000,000,000; and

1           “(viii) for calendar year 2026,  
2           \$4,000,000,000.

3           “(B) ALLOTMENTS.—

4           “(i) IN GENERAL.—In the case of a  
5           State with an application approved under  
6           this subsection with respect to a year, the  
7           Administrator shall allot to the State, in  
8           accordance with an allotment methodology  
9           specified by the Administrator that ensures  
10          that the spending requirement in para-  
11          graph (6) is met for the year, from  
12          amounts appropriated for such year under  
13          subparagraph (A), such amount as speci-  
14          fied by the Administrator with respect to  
15          the State and application and year.

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

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

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

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

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

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

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

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

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

7           “(5) PAYMENTS.—

8           “(A) ANNUAL PAYMENT OF ALLOT-  
9           MENTS.—Subject to subparagraph (B), the Ad-  
10          ministrator shall pay to each State that has an  
11          application approved under this subsection for a  
12          year, the allotment determined under paragraph  
13          (4)(B) for the State for the year.

14          “(B) MATCH REQUIRED.—

15          “(i) IN GENERAL.—The Administrator  
16          shall pay each State that has an applica-  
17          tion approved under this subsection for a  
18          year, the Federal percentage of the allot-  
19          ment determined for the State under para-  
20          graph (4)(B) for the year.

21          “(ii) FEDERAL AND STATE PERCENT-  
22          AGES DEFINED.—For purposes of clause  
23          (i), the Federal percentage is equal to 100  
24          percent reduced by the State percentage

1 for that year, and the State percentage is  
2 equal to—

3 “(I) in the case of calendar year  
4 2019, 0 percent;

5 “(II) in the case of calendar year  
6 2020, 0 percent;

7 “(III) in the case of calendar  
8 year 2021, 0 percent;

9 “(IV) in the case of calendar  
10 year 2022, 7 percent;

11 “(V) in the case of calendar year  
12 2023, 14 percent;

13 “(VI) in the case of calendar  
14 year 2024, 21 percent;

15 “(VII) in the case of calendar  
16 year 2025, 28 percent; and

17 “(VIII) in the case of calendar  
18 year 2026, 35 percent.

19 “(C) ADVANCE PAYMENT; RETROSPECTIVE  
20 ADJUSTMENT.—

21 “(i) IN GENERAL.—If the Adminis-  
22 trator deems it appropriate, the Adminis-  
23 trator shall make payments under this sub-  
24 section for each year on the basis of ad-  
25 vance estimates of expenditures submitted

1 by the State and such other investigation  
2 as the Administrator shall find necessary,  
3 and shall reduce or increase the payments  
4 as necessary to adjust for any overpayment  
5 or underpayment for prior years.

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

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

21 “(6) REQUIRED USE FOR PREMIUM STABILIZA-  
22 TION AND INCENTIVES FOR INDIVIDUAL MARKET  
23 PARTICIPATION.—In determining allotments for  
24 States under this subsection for each of calendar  
25 years 2019, 2020, and 2021, the Administrator shall

1 ensure that at least \$5,000,000,000 of the amounts  
2 appropriated for each such year under paragraph  
3 (4)(A) are used by States for the purposes described  
4 in paragraph (1)(A)(ii) and in accordance with guid-  
5 ance issued by the Administrator not later than 30  
6 days after the date of enactment of this subsection  
7 that specifies the parameters for the use of funds for  
8 such purposes.

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

12 (b) OTHER TITLE XXI AMENDMENTS.—

13 (1) Section 2101 of such Act (42 U.S.C.  
14 1397aa) is amended—

15 (A) in subsection (a), in the matter pre-  
16 ceding paragraph (1), by striking “The pur-  
17 pose” and inserting “Except with respect to  
18 short-term assistance activities under section  
19 2105(h) and the Long-Term State Stability and  
20 Innovation Program established in section  
21 2105(i), the purpose”; and

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

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

9           (3) Section 2106(a)(1) of such Act (42 U.S.C.  
10          1397ff(a)(1)) is amended by inserting “subsection  
11          (a) or (g) of” before “section 2105”.

12 **SEC. 107. BETTER CARE RECONCILIATION IMPLEMENTA-**  
13 **TION FUND.**

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

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



1 **SEC. 108. REPEAL OF THE TAX ON EMPLOYEE HEALTH IN-**  
2 **SURANCE PREMIUMS AND HEALTH PLAN**  
3 **BENEFITS.**

4 (a) IN GENERAL.—Chapter 43 of the Internal Rev-  
5 enue Code of 1986 is amended by striking section 4980L.

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

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

15 **SEC. 109. REPEAL OF TAX ON OVER-THE-COUNTER MEDICA-**  
16 **TIONS.**

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

20 (b) ARCHER MSAs.—Subparagraph (A) of section  
21 220(d)(2) of the Internal Revenue Code of 1986 is amend-  
22 ed by striking “Such term” and all that follows through  
23 the period.

24 (c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS  
25 AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Sec-

1 tion 106 of the Internal Revenue Code of 1986 is amended  
2 by striking subsection (f).

3 (d) EFFECTIVE DATES.—

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

8 (2) REIMBURSEMENTS.—The amendment made  
9 by subsection (c) shall apply to expenses incurred  
10 with respect to taxable years beginning after Decem-  
11 ber 31, 2016.

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

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

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

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

22 **SEC. 111. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO**  
23 **FLEXIBLE SPENDING ACCOUNTS.**

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

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

4 **SEC. 112. REPEAL OF TAX ON PRESCRIPTION MEDICA-**  
5 **TIONS.**

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

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

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

13 Section 4191 of the Internal Revenue Code of 1986  
14 is amended by adding at the end the following new sub-  
15 section:

16 “(d) APPLICABILITY.—The tax imposed under sub-  
17 section (a) shall not apply to sales after December 31,  
18 2017.”.

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

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

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

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

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

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

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

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

20 **SEC. 117. REPEAL OF MEDICARE TAX INCREASE.**

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

24 “(b) HOSPITAL INSURANCE.—In addition to the tax  
25 imposed by the preceding subsection, there is hereby im-  
26 posed on the income of every individual a tax equal to 1.45

1 percent of the wages (as defined in section 3121(a)) re-  
2 ceived by such individual with respect to employment (as  
3 defined in section 3121(b)).”

4 (b) SECA.—Subsection (b) of section 1401 of the In-  
5 ternal Revenue Code of 1986 is amended to read as fol-  
6 lows:

7 “(b) HOSPITAL INSURANCE.—In addition to the tax  
8 imposed by the preceding subsection, there shall be im-  
9 posed for each taxable year, on the self-employment in-  
10 come of every individual, a tax equal to 2.9 percent of the  
11 amount of the self-employment income for such taxable  
12 year.”

13 (c) EFFECTIVE DATE.—The amendments made by  
14 this section shall apply with respect to remuneration re-  
15 ceived after, and taxable years beginning after, December  
16 31, 2022.

17 **SEC. 118. REPEAL OF TANNING TAX.**

18 (a) IN GENERAL.—The Internal Revenue Code of  
19 1986 is amended by striking chapter 49.

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

23 **SEC. 119. REPEAL OF NET INVESTMENT TAX.**

24 (a) IN GENERAL.—Subtitle A of the Internal Rev-  
25 enue Code of 1986 is amended by striking chapter 2A.

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

4 **SEC. 120. REMUNERATION.**

5 Paragraph (6) of section 162(m) of the Internal Rev-  
6 enue Code of 1986 is amended by adding at the end the  
7 following new subparagraph:

8 “(I) TERMINATION.—This paragraph shall  
9 not apply to taxable years beginning after De-  
10 cember 31, 2016.”.

11 **SEC. 121. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAV-**  
12 **INGS ACCOUNT INCREASED TO AMOUNT OF**  
13 **DEDUCTIBLE AND OUT-OF-POCKET LIMITA-**  
14 **TION.**

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

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

22 (c) COST-OF-LIVING ADJUSTMENT.—Section  
23 223(g)(1) of such Code is amended—

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

1           (2) in subparagraph (B), by striking “deter-  
2           mined by” and all that follows through “‘calendar  
3           year 2003’.” and inserting “determined by sub-  
4           stituting ‘calendar year 2003’ for ‘calendar year  
5           1992’ in subparagraph (B) thereof.”.

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

9   **SEC. 122. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CON-**  
10                           **TRIBUTIONS TO THE SAME HEALTH SAVINGS**  
11                           **ACCOUNT.**

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

14                   “(5) SPECIAL RULE FOR MARRIED INDIVIDUALS  
15                   WITH FAMILY COVERAGE.—

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

22                                   “(i) the limitation under paragraph  
23                                   (1) shall be applied by not taking into ac-  
24                                   count any other high deductible health  
25                                   plan coverage of either spouse (and if such

1 spouses both have family coverage under  
2 separate high deductible health plans, only  
3 one such coverage shall be taken into ac-  
4 count),

5 “(ii) such limitation (after application  
6 of clause (i)) shall be reduced by the ag-  
7 gregate amount paid to Archer MSAs of  
8 such spouses for the taxable year, and

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

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



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

4 **SEC. 123. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES**  
5 **INCURRED BEFORE ESTABLISHMENT OF**  
6 **HEALTH SAVINGS ACCOUNT.**

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

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

21 (b) EFFECTIVE DATE.—The amendment made by  
22 this subsection shall apply with respect to coverage under  
23 a high deductible health plan beginning after December  
24 31, 2017.

1 **SEC. 124. FEDERAL PAYMENTS TO STATES.**

2 (a) IN GENERAL.—Notwithstanding section 504(a),  
3 1902(a)(23), 1903(a), 2002, 2005(a)(4), 2102(a)(7), or  
4 2105(a)(1) of the Social Security Act (42 U.S.C. 704(a),  
5 1396a(a)(23), 1396b(a), 1397a, 1397d(a)(4),  
6 1397bb(a)(7), 1397ee(a)(1)), or the terms of any Med-  
7 icaid waiver in effect on the date of enactment of this Act  
8 that is approved under section 1115 or 1915 of the Social  
9 Security Act (42 U.S.C. 1315, 1396n), for the 1-year pe-  
10 riod beginning on the date of enactment of this Act, no  
11 Federal funds provided from a program referred to in this  
12 subsection that is considered direct spending for any year  
13 may be made available to a State for payments to a pro-  
14 hibited entity, whether made directly to the prohibited en-  
15 tity or through a managed care organization under con-  
16 tract with the State.

17 (b) DEFINITIONS.—In this section:

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

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

23 (i) is an organization described in sec-  
24 tion 501(c)(3) of the Internal Revenue  
25 Code of 1986 and exempt from tax under  
26 section 501(a) of such Code;

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

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

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

12 (II) in the case where a woman  
13 suffers from a physical disorder, phys-  
14 ical injury, or physical illness that  
15 would, as certified by a physician,  
16 place the woman in danger of death  
17 unless an abortion is performed, in-  
18 cluding a life-endangering physical  
19 condition caused by or arising from  
20 the pregnancy itself; and

21 (B) for which the total amount of Federal  
22 and State expenditures under the Medicaid pro-  
23 gram under title XIX of the Social Security Act  
24 in fiscal year 2014 made directly to the entity  
25 and to any affiliates, subsidiaries, successors, or

1           clinics of the entity, or made to the entity and  
2           to any affiliates, subsidiaries, successors, or  
3           clinics of the entity as part of a nationwide  
4           health care provider network, exceeded  
5           \$350,000,000.

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

10 **SEC. 125. MEDICAID PROVISIONS.**

11       The Social Security Act is amended—

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

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

18               (B) in subsection (l)(2)(C), by inserting  
19               “and ending December 31, 2019,” after “Janu-  
20               ary 1, 2014,”;

21           (2) in section 1915(k)(2) (42 U.S.C.  
22           1396n(k)(2)), by striking “during the period de-  
23           scribed in paragraph (1)” and inserting “on or after  
24           the date referred to in paragraph (1) and before  
25           January 1, 2020”; and

1           (3) in section 1920(e) (42 U.S.C. 1396r-1(e)),  
2           by striking “under clause (i)(VIII), clause (i)(IX), or  
3           clause (ii)(XX) of subsection (a)(10)(A)” and insert-  
4           ing “under clause (i)(VIII) or clause (ii)(XX) of sec-  
5           tion 1902(a)(10)(A) before January 1, 2020, section  
6           1902(a)(10)(A)(i)(IX),”.

7 **SEC. 126. MEDICAID EXPANSION.**

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

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

11           (A) in subsection (a)(10)(A)—

12           (i) in clause (i)(VIII), by inserting  
13           “and ending December 31, 2019,” after  
14           “2014,”; and

15           (ii) in clause (ii), in subclause (XX),  
16           by inserting “and ending December 31,  
17           2017,” after “2014,” and by adding at  
18           the end the following new subclause:

19           “(XXIII) beginning January 1, 2020,  
20           who are expansion enrollees (as defined in  
21           subsection (nn)(1));”; and

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

24           “(nn) EXPANSION ENROLLEES.—

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

3                   “(A) who is under 65 years of age;

4                   “(B) who is not pregnant;

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

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

11                  “(E) whose income (as determined under  
12          subsection (e)(14)) does not exceed 133 percent  
13          of the poverty line (as defined in section  
14          2110(c)(5)) applicable to a family of the size in-  
15          volved.

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

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

24                          (A) in subsection (y)(1)—

1 (i) in the matter preceding subpara-  
2 graph (A), by striking “, with respect to”  
3 and all that follows through “shall be equal  
4 to” and inserting “and that has elected to  
5 cover newly eligible individuals before  
6 March 1, 2017, with respect to amounts  
7 expended by such State before January 1,  
8 2020, for medical assistance for newly eli-  
9 gible individuals described in subclause  
10 (VIII) of section 1902(a)(10)(A)(i), and,  
11 with respect to amounts expended by such  
12 State after December 31, 2019, and before  
13 January 1, 2024, for medical assistance  
14 for expansion enrollees (as defined in sec-  
15 tion 1902(m)(1)), shall be equal to the  
16 higher of the percentage otherwise deter-  
17 mined for the State and year under sub-  
18 section (b) (without regard to this sub-  
19 section) and”;

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

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

24 “(E) 90 percent for calendar quarters in  
25 2020;





1 after December 31, 2019 and before  
2 January 1, 2024, who are expansion  
3 enrollees (as defined in section  
4 1902(nn)(1)) shall be equal to the  
5 higher of the percentage otherwise de-  
6 termined for the State and year under  
7 subsection (b) (without regard to this  
8 subsection) and”; and

9 (ii) in subparagraph (B)(ii)—

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

12 (II) by striking subclauses (IV),  
13 (V), and (VI) and inserting the fol-  
14 lowing new subclause:

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

17 (b) SUNSET OF ESSENTIAL HEALTH BENEFITS RE-  
18 QUIREMENT.—Section 1937(b)(5) of the Social Security  
19 Act (42 U.S.C. 1396u–7(b)(5)) is amended by adding at  
20 the end the following: “This paragraph shall not apply  
21 after December 31, 2019.”.

22 **SEC. 127. RESTORING FAIRNESS IN DSH ALLOTMENTS.**

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

1 “(C) NON-EXPANSION STATES.—

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

5 “(I) subparagraph (A) shall not  
6 apply to the DSH allotment for such  
7 State and fiscal year; and

8 “(II) the DSH allotment for the  
9 State for fiscal year 2020 shall be in-  
10 creased by the amount calculated ac-  
11 cording to clause (iii).

12 “(ii) NO CHANGE IN REDUCTION FOR  
13 EXPANSION STATES.—In the case of a  
14 State that is an expansion State for a fis-  
15 cal year, the DSH allotment for such State  
16 and fiscal year shall be determined as if  
17 clause (i) did not apply.

18 “(iii) AMOUNT CALCULATED.—For  
19 purposes of clause (i)(II), the amount cal-  
20 culated according to this clause for a non-  
21 expansion State is the following:

22 “(I) For each State, the Sec-  
23 retary shall calculate a ratio equal to  
24 the State’s fiscal year 2016 DSH al-  
25 lotment divided by the number of indi-

1 individuals enrolled in the State plan  
2 under this title for such fiscal year.

3 “(II) The Secretary shall identify  
4 the States whose ratio as so deter-  
5 mined is below the national average of  
6 such ratio for all States.

7 “(III) The amount calculated  
8 pursuant to this clause is an amount  
9 that, if added to the State’s fiscal  
10 year 2016 DSH allotment, would in-  
11 crease the ratio calculated pursuant to  
12 subclause (I) up to the national aver-  
13 age for all States.

14 “(iv) DISREGARD OF INCREASE.—The  
15 DSH allotment for a non-expansion State  
16 for the second, third, and fourth quarters  
17 of fiscal year 2024 and fiscal years there-  
18 after shall be determined as if there had  
19 been no increase in the State’s DSH allot-  
20 ment for fiscal year 2020 under clause  
21 (i)(II).

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

24 “(I) The term ‘expansion State’  
25 means with respect to a fiscal year, a

1 State that, as of the date of enact-  
2 ment of this subparagraph, provided  
3 for eligibility under clause (i)(VIII) or  
4 (ii)(XX) of section 1902(a)(10)(A) for  
5 medical assistance under this title (or  
6 a waiver of the State plan approved  
7 under section 1115).

8 “(II) The term ‘non-expansion  
9 State’ means, with respect to a fiscal  
10 year, a State that is not an expansion  
11 State.”.

12 **SEC. 128. REDUCING STATE MEDICAID COSTS.**

13 (a) IN GENERAL.—

14 (1) STATE PLAN REQUIREMENTS.—Section  
15 1902(a)(34) of the Social Security Act (42 U.S.C.  
16 1396a(a)(34)) is amended by striking “in or after  
17 the third month before the month in which he made  
18 application” and inserting “in or after the month in  
19 which the individual made application”.

20 (2) DEFINITION OF MEDICAL ASSISTANCE.—  
21 Section 1905(a) of the Social Security Act (42  
22 U.S.C. 1396d(a)) is amended by striking “in or  
23 after the third month before the month in which the  
24 recipient makes application for assistance” and in-

1           serting “in or after the month in which the recipient  
2           makes application for assistance”.

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

8   **SEC. 129. PROVIDING SAFETY NET FUNDING FOR NON-EX-**  
9                                   **PANSION STATES.**

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

13          “ADJUSTMENT IN PAYMENT FOR SERVICES OF SAFETY  
14                                   NET PROVIDERS IN NON-EXPANSION STATES

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

1 waiver of such plan) to health care providers that provide  
2 health care services to individuals enrolled under this title  
3 (in this section referred to as ‘eligible providers’) so long  
4 as the payment adjustment to such an eligible provider  
5 does not exceed the provider’s costs in furnishing health  
6 care services (as determined by the Secretary and net of  
7 payments under this title, other than under this section,  
8 and by uninsured patients) to individuals who either are  
9 eligible for medical assistance under the State plan (or  
10 under a waiver of such plan) or have no health insurance  
11 or health plan coverage for such services.

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

18 “(1) 100 percent for calendar quarters in fiscal  
19 years 2018, 2019, 2020, and 2021; and

20 “(2) 95 percent for calendar quarters in fiscal  
21 year 2022.

22 “(c) ANNUAL ALLOTMENT LIMITATION.—Payment  
23 under section 1903(a) shall not be made to a State with  
24 respect to any payment adjustment made under this sec-

1 tion for all calendar quarters in a fiscal year in excess  
2 of the \$2,000,000,000 multiplied by the ratio of—

3 “(1) the population of the State with income  
4 below 138 percent of the poverty line in 2015 (as de-  
5 termined based the table entitled ‘Health Insurance  
6 Coverage Status and Type by Ratio of Income to  
7 Poverty Level in the Past 12 Months by Age’ for the  
8 universe of the civilian noninstitutionalized popu-  
9 lation for whom poverty status is determined based  
10 on the 2015 American Community Survey 1–Year  
11 Estimates, as published by the Bureau of the Cen-  
12 sus), to

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

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

21 **SEC. 130. ELIGIBILITY REDETERMINATIONS.**

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

1           “(J) FREQUENCY OF ELIGIBILITY REDE-  
2           TERMINATIONS.—Beginning on October 1,  
3           2017, and notwithstanding subparagraph (H),  
4           in the case of an individual whose eligibility for  
5           medical assistance under the State plan under  
6           this title (or a waiver of such plan) is deter-  
7           mined based on the application of modified ad-  
8           justed gross income under subparagraph (A)  
9           and who is so eligible on the basis of clause  
10          (i)(VIII), (ii)(XX), or (ii)(XXIII) of subsection  
11          (a)(10)(A), at the option of the State, the State  
12          plan may provide that the individual’s eligibility  
13          shall be redetermined every 6 months (or such  
14          shorter number of months as the State may  
15          elect).”.

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



1 respect to State expenditures attributable to activities car-  
2 ried out by the State (and approved by the Secretary) to  
3 exercise the option described in subparagraph (J) of such  
4 section (relating to eligibility redeterminations made on a  
5 6-month or shorter basis) (as added by subsection (a)) to  
6 increase the frequency of eligibility redeterminations.

7 **SEC. 131. OPTIONAL WORK REQUIREMENT FOR NON-**  
8 **DISABLED, NONELDERLY, NONPREGNANT IN-**  
9 **DIVIDUALS.**

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

14 “(00) OPTIONAL WORK REQUIREMENT FOR NON-  
15 DISABLED, NONELDERLY, NONPREGNANT INDIVID-  
16 UALS.—

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

23 “(2) WORK REQUIREMENT DEFINED.—In this  
24 section, the term ‘work requirement’ means, with re-  
25 spect to an individual, the individual’s participation

1 in work activities (as defined in section 407(d)) for  
2 such period of time as determined by the State, and  
3 as directed and administered by the State.

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

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

11 “(B) an individual who is under 19 years  
12 of age;

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

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

21 “(i) maintains satisfactory attendance  
22 at secondary school or the equivalent; or

23 “(ii) participates in education directly  
24 related to employment.”.

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

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

15 **SEC. 132. PROVIDER TAXES.**

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

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

52

1 “(I) for fiscal year 2021, ‘5.8  
2 percent’ shall be substituted for ‘6  
3 percent’ each place it appears;

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

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

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

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

17 **SEC. 133. PER CAPITA ALLOTMENT FOR MEDICAL ASSIST-**  
18 **ANCE.**

19 Title XIX of the Social Security Act is amended—

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

21 (A) in subsection (a), in the matter before  
22 paragraph (1), by inserting “and section  
23 1903A(a)” after “except as otherwise provided  
24 in this section”; and

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

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

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

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

10 “(1) IN GENERAL.—If a State which is one of  
11 the 50 States or the District of Columbia has excess  
12 aggregate medical assistance expenditures (as de-  
13 fined in paragraph (2)) for a fiscal year (beginning  
14 with fiscal year 2020), the amount of payment to  
15 the State under section 1903(a)(1) for each quarter  
16 in the following fiscal year shall be reduced by  $\frac{1}{4}$  of  
17 the excess aggregate medical assistance payments  
18 (as defined in paragraph (3)) for that previous fiscal  
19 year. In this section, the term ‘State’ means only the  
20 50 States and the District of Columbia.

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

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

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

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

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

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

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

23           “(A) the amount of the Federal payments  
24           that would be made to the State under section  
25           1903(a)(1) for medical assistance expenditures

1 for calendar quarters in the fiscal year if para-  
2 graph (1) did not apply; to

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

5 “(5) PER CAPITA BASE PERIOD.—

6 “(A) IN GENERAL.—In this section, the  
7 term ‘per capita base period’ means, with re-  
8 spect to a State, a period of 8 consecutive fiscal  
9 quarters selected by the State.

10 “(B) TIMELINE.—Each State shall submit  
11 its selection of 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 consecu-  
17 tive fiscal quarters for which all the data  
18 necessary to make determinations required  
19 under this section is available, as deter-  
20 mined by the Secretary; and

21 “(ii) shall not select any period of 8  
22 consecutive fiscal quarters that begins with  
23 a fiscal quarter earlier than the first quar-  
24 ter of fiscal year 2014 or ends with a fiscal

1 quarter later than the third fiscal quarter  
2 of 2017.

3 “(D) ADJUSTMENT BY THE SECRETARY.—

4 If the Secretary determines that a State took  
5 actions after the date of enactment of this sec-  
6 tion (including making retroactive adjustments  
7 to supplemental payment data in a manner that  
8 affects a fiscal quarter in the per capita base  
9 period) to diminish the quality of the data from  
10 the per capita base period used to make deter-  
11 minations under this section, the Secretary may  
12 adjust the data as the Secretary deems appro-  
13 priate.

14 “(b) ADJUSTED TOTAL MEDICAL ASSISTANCE EX-  
15 PENDITURES.—Subject to subsection (g), the following  
16 shall apply:

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

20 “(A) for the State’s per capita base period  
21 (as defined in subsection (a)(5)), the product  
22 of—

23 “(i) the amount of the medical assist-  
24 ance expenditures (as defined in paragraph  
25 (2) and adjusted under paragraph (5)) for



1 the State and period, reduced by the  
2 amount of any excluded expenditures (as  
3 defined in paragraph (3) and adjusted  
4 under paragraph (5)) for the State and pe-  
5 riod otherwise included in such medical as-  
6 sistance expenditures; and

7 “(ii) the 1903A base period popu-  
8 lation percentage (as defined in paragraph  
9 (4)) for the State; or

10 “(B) for fiscal year 2019 or a subsequent  
11 fiscal year, the amount of the medical assist-  
12 ance expenditures (as defined in paragraph (2))  
13 for the State and fiscal year that is attributable  
14 to 1903A enrollees, reduced by the amount of  
15 any excluded expenditures (as defined in para-  
16 graph (3)) for the State and fiscal year other-  
17 wise included in such medical assistance ex-  
18 penditures and includes non-DSH supplemental  
19 payments (as defined in subsection  
20 (d)(4)(A)(ii)) and payments described in sub-  
21 section (d)(4)(A)(iii) but shall not be construed  
22 as including any expenditures attributable to  
23 the program under section 1928 (relating to  
24 State pediatric vaccine distribution programs).  
25 In applying subparagraph (B), non-DSH sup-

1           plemental payments (as defined in subsection  
2           (d)(4)(A)(ii)) and payments described in sub-  
3           section (d)(4)(A)(iii) shall be treated as fully at-  
4           tributable to 1903A enrollees.

5           “(2) MEDICAL ASSISTANCE EXPENDITURES.—

6           In this section, the term ‘medical assistance expendi-  
7           tures’ means, for a State and fiscal year or per cap-  
8           ita base period, the medical assistance payments as  
9           reported by medical service category on the Form  
10          CMS-64 quarterly expense report (or successor to  
11          such a report form, and including enrollment data  
12          and subsequent adjustments to any such report, in  
13          this section referred to collectively as a ‘CMS-64 re-  
14          port’) for quarters in the year or base period for  
15          which payment is (or may otherwise be) made pur-  
16          suant to section 1903(a)(1), adjusted, in the case of  
17          a per capita base period, under paragraph (5).

18          “(3) EXCLUDED EXPENDITURES.—In this sec-  
19          tion, the term ‘excluded expenditures’ means, for a  
20          State and fiscal year or per capita base period, ex-  
21          penditures under the State plan (or under a waiver  
22          of such plan) that are attributable to any of the fol-  
23          lowing:

1           “(A) DSH.—Payment adjustments made  
2           for disproportionate share hospitals under sec-  
3           tion 1923.

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

7           “(C) SAFETY NET PROVIDER PAYMENT AD-  
8           JUSTMENTS IN NON-EXPANSION STATES.—Pay-  
9           ment adjustments under subsection (a) of sec-  
10          tion 1923A for which payment is permitted  
11          under subsection (c) of such section.

12          “(4) 1903A BASE PERIOD POPULATION PER-  
13          CENTAGE.—In this subsection, the term ‘1903A base  
14          period population percentage’ means, for a State,  
15          the Secretary’s calculation of the percentage of the  
16          actual medical assistance expenditures, as reported  
17          by the State on the CMS–64 reports for calendar  
18          quarters in the State’s per capita base period, that  
19          are attributable to 1903A enrollees (as defined in  
20          subsection (e)(1)).

21          “(5) ADJUSTMENTS FOR PER CAPITA BASE PE-  
22          RIOD.—In calculating medical assistance expendi-  
23          tures under paragraph (2) and excluded expendi-  
24          tures under paragraph (3) for a State for the State’s  
25          per capita base period, the total amount of each type

1 of expenditure for the State and base period shall be  
2 divided by 2.

3 “(c) TARGET TOTAL MEDICAL ASSISTANCE EXPEND-  
4 ITURES.—

5 “(1) CALCULATION.—In this section, the term  
6 ‘target total medical assistance expenditures’ means,  
7 for a State for a fiscal year and subject to para-  
8 graph (4), the sum of the products, for each of the  
9 1903A enrollee categories (as defined in subsection  
10 (e)(2)), of—

11 “(A) the target per capita medical assist-  
12 ance expenditures (as defined in paragraph (2))  
13 for the enrollee category, State, and fiscal year;  
14 and

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

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

22 “(A) for fiscal year 2020, an amount equal  
23 to—

24 “(i) the provisional FY19 target per  
25 capita amount for such enrollee category

1 (as calculated under subsection (d)(5)) for  
2 the State; increased by

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

6 “(B) for each succeeding fiscal year, an  
7 amount equal to—

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

13 “(ii) the applicable annual inflation  
14 factor for that succeeding fiscal year.

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

18 “(A) for fiscal years before 2025—

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

1                   September of the previous fiscal year to  
2                   September of the fiscal year involved; and

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

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

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

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

1 for a fiscal year (beginning with fiscal year  
2 2020), the target total medical assistance ex-  
3 penditures for such State and fiscal year shall  
4 be decreased by the amount that political sub-  
5 divisions in the State are required to contribute  
6 under the plan (or waiver) without reimburse-  
7 ment from the State for such fiscal year, other  
8 than contributions described in subparagraph  
9 (B).

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

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

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

19 “(II) imposes a local income tax  
20 upon its residents.

21 “(ii) Contributions required by a  
22 State from a political subdivision for ad-  
23 ministrative expenses if the State required  
24 such contributions from such subdivision

1 without reimbursement from the State as  
2 of January 1, 2017.

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

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

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

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



1           sistance expenditures for such category for  
2           the fiscal year involved shall be reduced by  
3           a percentage that shall be determined by  
4           the Secretary but which shall not be less  
5           than 0.5 percent or greater than 2 percent;  
6           or

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

18          “(C) RULES OF APPLICATION.—

19                   “(i) BUDGET NEUTRALITY REQUIRE-  
20          MENT.—In determining the appropriate  
21          percentages by which to adjust States’ tar-  
22          get per capita medical assistance expendi-  
23          tures for a category and fiscal year under  
24          this paragraph, the Secretary shall make  
25          such adjustments in a manner that does

1 not result in a net increase in Federal pay-  
2 ments under this section for such fiscal  
3 year, and if the Secretary cannot adjust  
4 such expenditures in such a manner there  
5 shall be no adjustment under this para-  
6 graph for such fiscal year.

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

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

1                   “(iv) DISREGARD OF ADJUSTMENT.—  
2                   Any adjustment under this paragraph to  
3                   target medical assistance expenditures for  
4                   a State, 1903A enrollee category, and fis-  
5                   cal year shall be disregarded when deter-  
6                   mining the target medical assistance ex-  
7                   penditures for such State and category for  
8                   a succeeding year under paragraph (2).

9                   “(v) APPLICATION FOR FISCAL YEARS  
10                  2020 AND 2021.—In fiscal years 2020 and  
11                  2021, the Secretary shall apply this para-  
12                  graph by deeming all categories of 1903A  
13                  enrollees to be a single category.

14                  “(D) PER CAPITA CATEGORICAL MEDICAL  
15                  ASSISTANCE EXPENDITURES.—

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

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

1                   “(II) the number of 1903A en-  
2                   rollees for the State, category, and  
3                   year.

4                   “(ii) CATEGORICAL MEDICAL ASSIST-  
5                   ANCE EXPENDITURES.—The term ‘categor-  
6                   ical medical assistance expenditures’  
7                   means, with respect to a State, 1903A en-  
8                   rollee category, and fiscal year, an amount  
9                   equal to the total medical assistance ex-  
10                  penditures (as defined in paragraph (2))  
11                  for the State and fiscal year that are at-  
12                  tributable to 1903A enrollees in the cat-  
13                  egory, excluding any excluded expenditures  
14                  (as defined in paragraph (3)) for the State  
15                  and fiscal year that are attributable to  
16                  1903A enrollees in the category.

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

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

24                  “(A) The amount of the adjusted total  
25                  medical assistance expenditures (as defined in

1 subsection (b)(1)) for the State for the State's  
2 per capita base period.

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

6 “(C) The average per capita medical as-  
7 sistance expenditures for the State for the  
8 State's per capita base period equal to—

9 “(i) the amount calculated under sub-  
10 paragraph (A); divided by

11 “(ii) the number calculated under sub-  
12 paragraph (B).

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

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

23 “(B) the percentage increase in the med-  
24 ical care component of the consumer price index  
25 for all urban consumers (U.S. city average)

1 from the last month of the State's per capita  
2 base period to September of fiscal year 2019.

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

7 “(A) The amount of the adjusted total  
8 medical assistance expenditures (as defined in  
9 subsection (b)(1)) for the State for fiscal year  
10 2019.

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

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

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

1 described in clause (iii) or non-DSH supple-  
2 mental expenditures (as defined in clause (ii)).

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

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

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

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

13 “(IV) complies with the limits for ad-  
14 ditional payments to providers under the  
15 plan (or waiver) imposed pursuant to sec-  
16 tion 1902(a)(30)(A), including the regula-  
17 tions specifying upper payment limits  
18 under the State plan in part 447 of title  
19 42, Code of Federal Regulations (or any  
20 successor regulations).

21 “(iii) An expenditure described in this  
22 clause is an expenditure that meets the criteria  
23 specified in subclauses (I), (II), and (III) of  
24 clause (ii) and is authorized under section 1115  
25 for the purposes of funding a delivery system

1 reform pool, uncompensated care pool, a des-  
2 ignated State health program, or any other  
3 similar expenditure (as defined by the Sec-  
4 retary).

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

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

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

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

23 “(D) For each 1903A enrollee category an  
24 average medical assistance expenditures per



1           capita for the State for fiscal year 2019 for the  
2           enrollee category equal to—

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

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

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

20                  “(5) PROVISIONAL FY19 PER CAPITA TARGET  
21                  AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—

22                  Subject to subsection (f)(2), the Secretary shall cal-  
23                  culate for each State a provisional FY19 per capita  
24                  target amount for each 1903A enrollee category  
25                  equal to the average medical assistance expenditures

1 per capita for the State for fiscal year 2019 (as cal-  
2 culated under paragraph (4)(D)) for such enrollee  
3 category multiplied by the ratio of—

4 “(A) the product of—

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

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

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

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

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

1           “(A) CHIP.—An individual who is pro-  
2           vided, under this title in the manner described  
3           in section 2101(a)(2), child health assistance  
4           under title XXI.

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

9           “(C) BREAST AND CERVICAL CANCER  
10           SERVICES ELIGIBLE INDIVIDUAL.—An indi-  
11           vidual who is eligible for medical assistance  
12           under this title only on the basis of section  
13           1902(a)(10)(A)(ii)(XVIII).

14           “(D) PARTIAL-BENEFIT ENROLLEES.—An  
15           individual who—

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

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

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

7           “(iv) is eligible for medical assistance  
8           under this title and for whom the State is  
9           providing a payment or subsidy to an em-  
10          ployer for coverage of the individual under  
11          a group health plan pursuant to section  
12          1906 or section 1906A (or pursuant to a  
13          waiver that provides only comparable bene-  
14          fits).

15          “(E) BLIND AND DISABLED CHILDREN.—

16          An individual who—

17                 “(i) is a child under 19 years of age;  
18                 and

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

22          “(2) 1903A ENROLLEE CATEGORY.—The term  
23          ‘1903A enrollee category’ means each of the fol-  
24          lowing:

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

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

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

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

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

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

19           “(E) OTHER NONELDERLY, NONDISABLED,  
20           NON-EXPANSION ADULTS.—A category of  
21           1903A enrollees who are not described in any  
22           previous subparagraph.

23           “(3) MEDICAID ENROLLEE.—The term ‘Med-  
24           icaid enrollee’ means, with respect to a State for a  
25           month, an individual who is eligible for medical as-

1 assistance for items or services under this title and en-  
2 rolled under the State plan (or a waiver of such  
3 plan) under this title for the month.

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

13 “(f) SPECIAL PAYMENT RULES.—

14 “(1) APPLICATION IN CASE OF RESEARCH AND  
15 DEMONSTRATION PROJECTS AND OTHER WAIVERS.—  
16 In the case of a State with a waiver of the State  
17 plan approved under section 1115, section 1915, or  
18 another provision of this title, this section shall  
19 apply to medical assistance expenditures and medical  
20 assistance payments under the waiver, in the same  
21 manner as if such expenditures and payments had  
22 been made under a State plan under this title and  
23 the limitations on expenditures under this section  
24 shall supersede any other payment limitations or  
25 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 FISCAL YEAR 2016.—In the case of a  
5        State that did not provide for medical assistance for  
6        the 1903A enrollee category described in subsection  
7        (e)(2)(D) during fiscal year 2016 but which provides  
8        for such assistance for such category in a subse-  
9        quent year, the provisional FY19 per capita target  
10       amount for such enrollee category under subsection  
11       (d)(5) shall be equal to the provisional FY19 per  
12       capita target amount for the 1903A enrollee cat-  
13       egory described in 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.”.

1 **SEC. 134. FLEXIBLE BLOCK GRANT OPTION FOR STATES.**

2 Title XIX of the Social Security Act, as amended by  
3 section 133, is further amended by inserting after section  
4 1903A the following new section:

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

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

11 “(b) STATE APPLICATION.—

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

16 “(2) CONTENTS OF APPLICATION.—An applica-  
17 tion under this subsection shall include the fol-  
18 lowing:

19 “(A) A description of the proposed Med-  
20 icaid Flexibility Program and how the State will  
21 satisfy the requirements described in subsection  
22 (d).

23 “(B) The proposed conditions for eligibility  
24 of program enrollees.

25 “(C) A description of the types, amount,  
26 duration, and scope of services which will be of-

1           ferred as targeted health assistance under the  
2           program, including a description of the pro-  
3           posed package of services which will be provided  
4           to program enrollees to whom the State would  
5           otherwise be required to make medical assist-  
6           ance available under section 1902(a)(10)(A)(i).

7           “(D) A description of how the State will  
8           notify individuals currently enrolled in the State  
9           plan for medical assistance under this title of  
10          the transition to such program.

11          “(E) Statements certifying that the State  
12          agrees to—

13                 “(i) submit regular enrollment data  
14                 with respect to the program to the Centers  
15                 for Medicare & Medicaid Services at such  
16                 time and in such manner as the Secretary  
17                 may require;

18                 “(ii) submit timely and accurate data  
19                 to the Transformed Medicaid Statistical  
20                 Information System (T-MSIS);

21                 “(iii) report annually to the Secretary  
22                 on adult health quality measures imple-  
23                 mented under the program and informa-  
24                 tion on the quality of health care furnished  
25                 to program enrollees under the program as

1 part of the annual report required under  
2 section 1139B(d)(1);

3 “(iv) submit such additional informa-  
4 tion not described in any of the preceding  
5 clauses of this subparagraph but which the  
6 Secretary determines is necessary for mon-  
7 itoring, evaluation, or program integrity  
8 purposes, including—

9 “(I) survey data, such as the  
10 data from Consumer Assessment of  
11 Healthcare Providers and Systems  
12 (CAHPS) surveys;

13 “(II) birth certificate data; and

14 “(III) clinical patient data for  
15 quality measurements which may not  
16 be present in a claim, such as labora-  
17 tory data, body mass index, and blood  
18 pressure; and

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

22 “(F) An information technology systems  
23 plan demonstrating that the State has the capa-  
24 bility to support the technological administra-



1           tion of the program and comply with reporting  
2           requirements under this section.

3           “(G) A statement of the goals of the pro-  
4           posed program, which shall include—

5                   “(i) goals related to quality, access,  
6                   rate of growth targets, consumer satisfac-  
7                   tion, and outcomes;

8                   “(ii) a plan for monitoring and evalu-  
9                   ating the program to determine whether  
10                  such goals are being met; and

11                  “(iii) a proposed process for the State,  
12                  in consultation with the Centers for Medi-  
13                  care & Medicaid Services, to take remedial  
14                  action to make progress on unmet goals.

15           “(H) Such other information as the Sec-  
16           retary may require.

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

18                   “(A) IN GENERAL.—Before submitting an  
19                   application under this subsection, a State shall  
20                   make the application publicly available for a 30  
21                   day notice and comment period.

22                   “(B) NOTICE AND COMMENT PROCESS.—  
23                   During the notice and comment period de-  
24                   scribed in subparagraph (A), the State shall  
25                   provide opportunities for a meaningful level of

1 public input, which shall include public hearings  
2 on the proposed Medicaid Flexibility Program.

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

8 “(5) TIMELINE FOR SUBMISSION.—

9 “(A) IN GENERAL.—A State may submit  
10 an application under this subsection to conduct  
11 a Medicaid Flexibility Program that would  
12 begin in the next fiscal year at any time, sub-  
13 ject to subparagraph (B).

14 “(B) DEADLINES.—Each year beginning  
15 with 2019, the Secretary shall specify a dead-  
16 line for submitting an application under this  
17 subsection to conduct a Medicaid Flexibility  
18 Program that would begin in the next fiscal  
19 year, but such deadline shall not be earlier than  
20 60 days after the date that the Secretary pub-  
21 lishes the amounts of State block grants as re-  
22 quired under subsection (c)(4).

23 “(c) FINANCING.—

24 “(1) IN GENERAL.—For each fiscal year during  
25 which a State is conducting a Medicaid Flexibility

1 Program, the State shall receive, instead of amounts  
2 otherwise payable to the State under this title for  
3 medical assistance for program enrollees, the  
4 amount specified in paragraph (3)(A).

5 “(2) AMOUNT OF BLOCK GRANT FUNDS.—

6 “(A) FOR INITIAL YEAR.—Subject to sub-  
7 paragraph (C), for the first fiscal year in which  
8 a State conducts a Medicaid Flexibility Pro-  
9 gram, the block grant amount under this para-  
10 graph for the State and year shall be equal to  
11 the Federal average medical assistance match-  
12 ing percentage (as defined in section  
13 1903A(a)(4)) for the State and year multiplied  
14 by the product of—

15 “(i) the target per capita medical as-  
16 sistance expenditures (as defined in section  
17 1903A(c)(2)) for the State and year for  
18 the enrollee category described in section  
19 1903A(e)(2)(E); and

20 “(ii) the number of 1903A enrollees in  
21 such category for the State for the second  
22 fiscal year preceding such first fiscal year,  
23 increased by the percentage increase in  
24 State population from such second pre-  
25 ceding fiscal year to such first fiscal year,

1 based on the best available estimates of the  
2 Bureau of the Census.

3 “(B) FOR ANY SUBSEQUENT YEAR.—For  
4 any fiscal year that is not the first fiscal year  
5 in which a State conducts a Medicaid Flexibility  
6 Program, the block grant amount under this  
7 paragraph for the State and year shall be equal  
8 to the block grant amount determined for the  
9 State for the most recent previous fiscal year in  
10 which the State conducted a Medicaid Flexi-  
11 bility Program, except that such amount shall  
12 be increased by the percentage increase in the  
13 consumer price index for all urban consumers  
14 (U.S. city average) from April of the second fis-  
15 cal year preceding the fiscal year involved to  
16 April of the fiscal year preceding the fiscal year  
17 involved.

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

21 “(i) IN GENERAL.—In calculating the  
22 amount of a block grant for the first year  
23 in which a State conducts a Medicaid  
24 Flexibility Program under subparagraph  
25 (A), the total number of 1903A enrollees

1 in the 1903A enrollee category described in  
2 section 1903A(e)(2)(E) for the State and  
3 year shall not exceed the adjusted number  
4 of base period non-expansion enrollees for  
5 the State (as defined in clause (ii)).

6 “(ii) ADJUSTED NUMBER OF 2016  
7 NON-EXPANSION ENROLLEES.—The term  
8 ‘adjusted number of base period non-ex-  
9 pansion enrollees’ means, with respect to a  
10 State, the number of 1903A enrollees in  
11 the enrollee category described in section  
12 1903A(e)(2)(E) for the State for the  
13 State’s per capita base period (as deter-  
14 mined under section 1903A(e)(4)), in-  
15 creased by the percentage increase, if any,  
16 in the total State population from the last  
17 April in the State’s per capita base period  
18 to April of the fiscal year preceding the fis-  
19 cal year involved (determined using the  
20 best available data from the Bureau of the  
21 Census) plus 3 percentage points.

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

24 “(i) IN GENERAL.—To the extent that  
25 the block grant amount available to a

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

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

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

14 “(ii) USE OF FUNDS.—Section  
15 1903(i)(17) shall not apply to funds made  
16 available to a State under this subpara-  
17 graph and a State may use such funds for  
18 other State health programs (as defined or  
19 approved by the Secretary) or for any  
20 other purpose which is consistent with the  
21 quality standards established by the Sec-  
22 retary under clause (iii).

23 “(iii) QUALITY STANDARDS.—

24 “(I) IN GENERAL.—Not later  
25 than January 1, 2020, the Secretary

1 shall establish quality standards appli-  
2 cable to a State's use of funds made  
3 available to the State under this sub-  
4 paragraph.

5 “(II) ALLOWABLE USES.—In es-  
6 tablishing quality standards under  
7 this clause, the Secretary shall not  
8 prohibit a State from using such  
9 funds for—

10 “(aa) a program that is not  
11 related to health care, provided  
12 that using the funds for such  
13 program is otherwise consistent  
14 with the standards; or

15 “(bb) the State maintenance  
16 of effort expenditures required  
17 under paragraph (3)(B).

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

19  
20 “(A) FEDERAL PAYMENT.—Subject to sub-  
21 paragraph (D), the Secretary shall pay to each  
22 State conducting a Medicaid Flexibility Pro-  
23 gram under this section for a fiscal year, from  
24 its block grant amount under paragraph (2) for  
25 such year, an amount for each quarter of such

1 year equal to the Federal average medical as-  
2 sistance percentage (as defined in section  
3 1903A(a)(4)) of the total amount expended  
4 under the program during such quarter, and  
5 the State is responsible for the balance of the  
6 funds to carry out such program.

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

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

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

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

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



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

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

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

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

22                  “(d) PROGRAM REQUIREMENTS.—

23                  “(1) IN GENERAL.—No payment shall be made  
24                  under this section to a State conducting a Medicaid

1 Flexibility Program unless such program meets the  
2 requirements of this subsection.

3 “(2) TERM OF PROGRAM.—

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

7 “(i) shall be conducted for not less  
8 than 1 program period;

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

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

16 “(II) no significant changes are  
17 made to the program; and

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

22 “(B) ELECTION TO TERMINATE PRO-  
23 GRAM.—

24 “(i) IN GENERAL.—Subject to clause  
25 (ii), a State conducting a Medicaid Flexi-

1 bility Program may elect to terminate the  
2 program effective with the first day after  
3 the end of the program period in which the  
4 State makes the election.

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

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

18 “(3) PROVISION OF TARGETED HEALTH ASSIST-  
19 ANCE.—

20 “(A) IN GENERAL.—A State Medicaid  
21 Flexibility Program shall provide targeted  
22 health assistance to program enrollees and such  
23 assistance shall be instead of medical assistance  
24 which would otherwise be provided to the enroll-  
25 ees under this title.

1 “(B) CONDITIONS FOR ELIGIBILITY.—

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

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

19 “(4) BENEFITS AND SERVICES.—

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

1           gram shall provide as targeted health assistance  
2           the following types of services:

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

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

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

8                   “(iv) Physician services.

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

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

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

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

18                  “(ix) Nurse midwife services.

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

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

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

25                  “(xiii) Non-cosmetic dental services.

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

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

10          “(C) BENEFIT PACKAGES.—

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

24           “(ii) AMOUNT, DURATION, AND SCOPE  
25           OF BENEFITS.—Subject to clause (i), the

1 State shall determine the amount, dura-  
2 tion, and scope with respect to services  
3 provided as targeted health assistance  
4 under a Medicaid Flexibility Program, in-  
5 cluding with respect to services that are re-  
6 quired to be provided to certain program  
7 enrollees under subparagraph (A) except  
8 as otherwise provided under such subpara-  
9 graph.

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

23 “(iv) PRESCRIPTION DRUGS.—If the  
24 targeted health assistance provided by a  
25 State to program enrollees under a Med-



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

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

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

1           “(A) SINGLE AGENCY.—Designate a single  
2 State agency responsible for administering the  
3 program.

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

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

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

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

22           “(B) APPLICATION OF SECTION 1903A.—  
23 With respect to a State that is conducting a  
24 Medicaid Flexibility Program, section 1903A  
25 shall be applied as if program enrollees were

1 not 1903A enrollees for each program period  
2 during which the State conducts the program.

3 “(C) WAIVERS AND STATE PLAN AMEND-  
4 MENTS.—

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

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

21 “(iii) EFFECT OF TERMINATION.—In  
22 the case of a State described in clause (i)  
23 that terminates its program under sub-  
24 section (d)(2)(B), any waiver or amend-  
25 ment which was limited pursuant to sub-

1 paragraph (A) shall cease to be so limited  
2 effective with the effective date of such ter-  
3 mination.

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

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

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

19 “(2) PROGRAM ENROLLEE.—

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

1 enrollee category described in section  
2 1903A(e)(2)(E).

3 “(B) RULE OF CONSTRUCTION.—For pur-  
4 poses of section 1903A(e)(3), eligibility and en-  
5 rollment of an individual under a Medicaid  
6 Flexibility Program shall be deemed to be eligi-  
7 bility and enrollment under a State plan (or  
8 waiver of such plan) under this title.

9 “(3) PROGRAM PERIOD.—The term ‘program  
10 period’ means, with respect to a State Medicaid  
11 Flexibility Program, a period of 5 consecutive fiscal  
12 years that begins with either—

13 “(A) the first fiscal year in which the State  
14 conducts the program; or

15 “(B) the next fiscal year in which the  
16 State conducts such a program that begins  
17 after the end of a previous program period.

18 “(4) STATE.—The term ‘State’ means one of  
19 the 50 States or the District of Columbia.

20 “(5) TARGETED HEALTH ASSISTANCE.—The  
21 term ‘targeted health assistance’ means assistance  
22 for health-care-related items and medical services for  
23 program enrollees.”

1 **SEC. 135. MEDICAID AND CHIP QUALITY PERFORMANCE**  
2 **BONUS PAYMENTS.**

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

6 “(aa) **QUALITY PERFORMANCE BONUS PAYMENTS.**—

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

12 “(A) equals or exceeds the qualifying  
13 amount (as established by the Secretary) of  
14 lower than expected aggregate medical assist-  
15 ance expenditures (as defined in paragraph (4))  
16 for that fiscal year; and

17 “(B) submits to the Secretary, in accord-  
18 ance with such manner and format as specified  
19 by the Secretary and for the performance pe-  
20 riod (as defined by the Secretary) for such fis-  
21 cal year—

22 “(i) information on the applicable  
23 quality measures identified under para-  
24 graph (3) with respect to each category of  
25 Medicaid eligible individuals under the  
26 State plan or a waiver of such plan; and



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

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

22          “(4) LOWER THAN EXPECTED AGGREGATE  
23          MEDICAL ASSISTANCE EXPENDITURES.—In this sub-  
24          section, the term ‘lower than expected aggregate



1 medical assistance expenditures’ means, with respect  
2 to a State the amount (if any) by which—

3 “(A) the amount of the adjusted total med-  
4 ical assistance expenditures for the State and  
5 fiscal year determined in section 1903A(b)(1)  
6 without regard to the 1903A enrollee category  
7 described in section 1903A(e)(2)(E); is less  
8 than

9 “(B) the amount of the target total med-  
10 ical assistance expenditures for the State and  
11 fiscal year determined in section 1903A(c) with-  
12 out regard to the 1903A enrollee category de-  
13 scribed in section 1903A(e)(2)(E).”.

14 **SEC. 136. GRANDFATHERING CERTAIN MEDICAID WAIVERS;**

15 **PRIORITIZATION OF HCBS WAIVERS.**

16 (a) **MANAGED CARE WAIVERS.—**

17 (1) **IN GENERAL.—**In the case of a State with  
18 a grandfathered managed care waiver, the State  
19 may, at its option through a State plan amendment,  
20 continue to implement the managed care delivery  
21 system that is the subject of such waiver in per-  
22 petuity under the State plan under title XIX of the  
23 Social Security Act (or a waiver of such plan) with-  
24 out submitting an application to the Secretary for a  
25 new waiver to implement such managed care delivery

1 system, so long as the terms and conditions of the  
2 waiver involved (other than such terms and condi-  
3 tions that relate to budget neutrality as modified  
4 pursuant to section 1903A(f)(1) of the Social Secu-  
5 rity Act) are not modified.

6 (2) MODIFICATIONS.—

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

13 (B) APPROVAL OF MODIFICATION.—

14 (i) IN GENERAL.—An application de-  
15 scribed in subparagraph (A) is deemed ap-  
16 proved unless the Secretary, not later than  
17 90 days after the date on which the appli-  
18 cation is submitted, submits to the State—

19 (I) a denial; or

20 (II) a request for more informa-  
21 tion regarding the application.

22 (ii) ADDITIONAL INFORMATION.—If  
23 the Secretary requests additional informa-  
24 tion, the Secretary has 30 days after a  
25 State submission in response to the Sec-

1           retary’s request to deny the application or  
2           request more information.

3           (3) GRANDFATHERED MANAGED CARE WAIVER  
4           DEFINED.—In this subsection, the term “grand-  
5           fathered managed care waiver” means the provisions  
6           of a waiver or an experimental, pilot, or demonstra-  
7           tion project that relate to the authority of a State  
8           to implement a managed care delivery system under  
9           the State plan under title XIX of such Act (or under  
10          a waiver of such plan under section 1115 of such  
11          Act) that—

12                   (A) is approved by the Secretary of Health  
13                   and Human Services under section 1915(b),  
14                   1932, or 1115(a)(1) of the Social Security Act  
15                   (42 U.S.C. 1396n(b), 1396u–2, 1315(a)(1)) as  
16                   of January 1, 2017; and

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

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

1 **SEC. 137. COORDINATION WITH STATES.**

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

5 “COORDINATION WITH STATES

6 “SEC. 1904A. No proposed rule (as defined in section  
7 551(4) of title 5, United States Code) implementing or  
8 interpreting any provision of this title shall be finalized  
9 on or after January 1, 2018, unless the Secretary—

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

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

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

1           “(2) accepts and considers written and oral  
2           comments from a bipartisan, nonprofit, professional  
3           organization that represents State Medicaid Direc-  
4           tors, and from any State agency administering the  
5           plan under this title, regarding such proposed rule;  
6           and

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

11 **SEC. 138. OPTIONAL ASSISTANCE FOR CERTAIN INPATIENT**  
12 **PSYCHIATRIC SERVICES.**

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

15               (1) in subsection (a)—

16                   (A) in paragraph (16)—

17                           (i) by striking “and, (B)” and insert-  
18                           ing “(B)”; and

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

1 (B) in the subdivision (B) that follows  
2 paragraph (29), by inserting “(other than serv-  
3 ices described in subparagraph (C) of para-  
4 graph (16) for individuals described in such  
5 subparagraph)” after “patient in an institution  
6 for mental diseases”; and

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

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

15 “(A) in an institution (or distinct part thereof)  
16 which is a psychiatric hospital (as defined in section  
17 1861(f)); and

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

22 “(4) As a condition for a State including qualified  
23 inpatient psychiatric hospital services as medical assist-  
24 ance under subsection (a)(16)(C), the State must (during  
25 the period in which it furnishes medical assistance under

1 this title for services and individuals described in such  
2 subsection)—

3 “(A) maintain at least the number of licensed  
4 beds at psychiatric hospitals owned, operated, or  
5 contracted for by the State that were being main-  
6 tained as of the date of the enactment of this para-  
7 graph or, if higher, as of the date the State applies  
8 to the Secretary to include medical assistance under  
9 such subsection; and

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

21 (b) SPECIAL MATCHING RATE.—Section 1905(b) of  
22 the Social Security Act (42 U.S.C. 1395d(b)) is amended  
23 by adding at the end the following: “Notwithstanding the  
24 previous provisions of this subsection, the Federal medical  
25 assistance percentage shall be 50 percent with respect to

1 medical assistance for services and individuals described  
2 in subsection (a)(16)(C).”.

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

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

7 (a) TAX TREATMENT OF SMALL BUSINESS HEALTH  
8 PLANS.—For purposes of applying subchapter B of chap-  
9 ter 100 of the Internal Revenue Code of 1986, title XXVII  
10 of the Public Health Service Act (42 U.S.C. 300gg et  
11 seq.), and part 7 of title I of the Employee Retirement  
12 Income Security Act of 1974 (29 U.S.C. 1181 et seq.),  
13 a small business health plan as defined in section 801(a)  
14 of the Employee Retirement Income Security Act of 1974  
15 that is offered to employees shall be treated as a group  
16 health plan, as defined in section 2791 of the Public  
17 Health Service Act (42 U.S.C. 300gg–91).

18 (b) IN GENERAL.—Subtitle B of title I of the Em-  
19 ployee Retirement Income Security Act of 1974 (29  
20 U.S.C. 1021 et seq.) is amended by adding at the end  
21 the following new part:



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

2                                   **RISK SHARING POOLS**

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

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

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

11                   “(1) such sponsor is a qualified sponsor and re-  
12 ceives certification by the Secretary;

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

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

18                   “(4) is established for a purpose other than  
19 providing health benefits to its members, such as an  
20 organization established as a bona fide trade asso-  
21 ciation; and

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

1 **“SEC. 802. FILING FEE AND CERTIFICATION OF SMALL**  
2 **BUSINESS HEALTH PLANS.**

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

10 “(b) CERTIFICATION.—

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

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

19 “(B) may provide for continued certifi-  
20 cation of small business health plans under this  
21 part; and

22 “(C) shall provide for the revocation of a  
23 certification if the applicable authority finds  
24 that the small business health plan involved  
25 fails to comply with the requirements of this  
26 part.

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

8                   “(A) Identifying information.

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

11                   “(C) Bonding requirements.

12                   “(D) Plan documents.

13                   “(E) Agreements with service providers.

14           “(c) FILING NOTICE OF CERTIFICATION WITH  
15           STATES.—A certification granted under this part to a  
16           small business health plan shall not be effective unless  
17           written notice of such certification is filed with the appli-  
18           cable State authority of each State in which the small  
19           business health plans operate.

20           “(d) NOTICE OF MATERIAL CHANGES.—In the case  
21           of any small business health plan certified under this part,  
22           descriptions of material changes in any information which  
23           was required to be submitted with the application for the  
24           certification under this part shall be filed in such form  
25           and manner as shall be prescribed by the applicable au-

1 thority by regulation. The applicable authority may re-  
2 quire by regulation prior notice of material changes with  
3 respect to specified matters which might serve as the basis  
4 for suspension or revocation of the certification.

5 “(e) NOTICE REQUIREMENTS FOR VOLUNTARY TER-  
6 MINATION.—A small business health plan which is or has  
7 been certified under this part may terminate (upon or at  
8 any time after cessation of accruals in benefit liabilities)  
9 only if the board of trustees, not less than 60 days before  
10 the proposed termination date—

11 “(1) provides to the participants and bene-  
12 ficiaries a written notice of intent to terminate stat-  
13 ing that such termination is intended and the pro-  
14 posed termination date;

15 “(2) develops a plan for winding up the affairs  
16 of the plan in connection with such termination in  
17 a manner which will result in timely payment of all  
18 benefits for which the plan is obligated; and

19 “(3) submits such plan in writing to the appli-  
20 cable authority.

21 “(f) OVERSIGHT OF CERTIFIED PLAN SPONSORS.—  
22 The Secretary has the discretion to determine whether any  
23 person has violated or is about to violate any provision  
24 of this part, and may conduct periodic review of certified  
25 small business health plan sponsors, consistent with sec-

1 tion 504, and apply the requirements of sections 518, 519,  
2 and 520.

3 “(g) EXPEDITED AND DEEMED CERTIFICATION.—

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

11 “(2) PENALTY.—The Secretary may assess a  
12 penalty against the board of trustees and plan spon-  
13 sor (jointly and severally) of a small business health  
14 plan sponsor that is deemed certified under para-  
15 graph (1) of up to \$500,000 in the event the Sec-  
16 retary determines that the application for certifi-  
17 cation of such small business health plan sponsor  
18 was willfully or with gross negligence incomplete or  
19 inaccurate.

20 “(h) MODIFICATIONS.—The Secretary shall, through  
21 promulgation and implementation of such regulations as  
22 the Secretary may reasonably determine necessary or ap-  
23 propriate, and in consultation with a balanced spectrum  
24 of effected entities and persons, modify the implementa-  
25 tion and application of this part to accommodate with min-

1 imum disruption such changes to State or Federal law  
2 provided in this part and the (and the amendments made  
3 by such Act) or in regulations issued thereto.

4 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**  
5 **BOARDS OF TRUSTEES.**

6 “(a) BOARD OF TRUSTEES.—The Secretary shall en-  
7 sure that Board of Trustees of a small business health  
8 plan certified under this part complies with the require-  
9 ments such Secretary sets forth with respect to fiscal con-  
10 trol and rules of operation and financial controls.

11 “(b) TREATMENT OF FRANCHISES.—In the case of  
12 a group health plan that is established and maintained  
13 by a franchisor for a franchisor or for its franchisees—

14 “(1) the requirements of subsection (a) and sec-  
15 tion 801(a) shall be deemed met if such require-  
16 ments would otherwise be met if the franchisor were  
17 deemed to be the sponsor referred to in section  
18 801(b) and each franchisee were deemed to be a  
19 member (of the sponsor) referred to in section  
20 801(b); and

21 “(2) the requirements of section 804(a)(1) shall  
22 be deemed met.

1 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**  
2 **MENTS.**

3 “(a) COVERED EMPLOYERS AND INDIVIDUALS.—The  
4 requirements of this subsection are met with respect to  
5 a small business health plan if, under the terms of the  
6 plan—

7 “(1) each participating employer must be—

8 “(A) a member of the sponsor;

9 “(B) the sponsor; or

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

20 “(2) all individuals commencing coverage under  
21 the plan after certification under this part must  
22 be—

23 “(A) active or retired owners (including  
24 self-employed individuals), officers, directors, or  
25 employees of, or partners in, participating em-  
26 ployers; or





1           “(B) in the case of a sponsor with mem-  
2           bers which consist of associations, a person who  
3           is a member or employee of any such associa-  
4           tion and elects an affiliated status with the  
5           sponsor.

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

13          “(3) FRANCHISOR; FRANCHISEE.—The terms  
14          ‘franchisor’ and ‘franchisee’ have the meanings given  
15          such terms for purposes of sections 436.2(a)  
16          through 436.2(c) of title 16, Code of Federal Regu-  
17          lations (including any such amendments to such reg-  
18          ulation after the date of enactment of this part).

19          “(4) HEALTH PLAN TERMS.—The terms ‘group  
20          health plan’, ‘health insurance coverage’, and ‘health  
21          insurance issuer’ have the meanings provided in sec-  
22          tion 733.

23          “(5) INDIVIDUAL MARKET.—

24                 “(A) IN GENERAL.—The term ‘individual  
25          market’ means the market for health insurance

1 coverage offered to individuals other than in  
2 connection with a group health plan.

3 “(B) TREATMENT OF VERY SMALL  
4 GROUPS.—

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

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

21 “(6) PARTICIPATING EMPLOYER.—The term  
22 ‘participating employer’ means, in connection with a  
23 small business health plan, any employer, if any in-  
24 dividual who is an employee of such employer, a  
25 partner in such employer, or a self-employed indi-

1       vidual who is such employer (or any dependent, as  
2       defined under the terms of the plan, of such indi-  
3       vidual) is or was covered under such plan in connec-  
4       tion with the status of such individual as such an  
5       employee, partner, or self-employed individual in re-  
6       lation to the plan.

7       “(b) RENEWAL.—A participating employer in a small  
8       business health plan shall not be deemed to be a plan  
9       sponsor in applying requirements relating to coverage re-  
10      newal.”.

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

15      “(e) Except as provided in subsection (b)(4), the pro-  
16      visions of this title shall supersede any and all State laws  
17      insofar as they may now or hereafter preclude a health  
18      insurance issuer from offering health insurance coverage  
19      in connection with a small business health plan which is  
20      certified under part 8.”.

21      (d) PLAN SPONSOR.—Section 3(16)(B) of such Act  
22      (29 U.S.C. 102(16)(B)) is amended by adding at the end  
23      the following new sentence: “Such term also includes a  
24      person serving as the sponsor of a small business health  
25      plan under part 8.”.

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

3 (f) COOPERATION BETWEEN FEDERAL AND STATE  
4 AUTHORITIES.—Section 506 of the Employee Retirement  
5 Income Security Act of 1974 (29 U.S.C. 1136) is amended  
6 by adding at the end the following new subsection:

7 “(d) CONSULTATION WITH STATES WITH RESPECT  
8 TO SMALL BUSINESS HEALTH PLANS.—

9 “(1) AGREEMENTS WITH STATES.—The Sec-  
10 retary shall consult with the State recognized under  
11 paragraph (2) with respect to a small business  
12 health plan regarding the exercise of—

13 “(A) the Secretary’s authority under sec-  
14 tions 502 and 504 to enforce the requirements  
15 for certification under part 8; and

16 “(B) the Secretary’s authority to certify  
17 small business health plans under part 8 in ac-  
18 cordance with regulations of the Secretary ap-  
19 plicable to certification under part 8.

20 “(2) RECOGNITION OF DOMICILE STATE.—In  
21 carrying out paragraph (1), the Secretary shall en-  
22 sure that only one State will be recognized, with re-  
23 spect to any particular small business health plan,  
24 as the State with which consultation is required.”.

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

## 7 TITLE II

### 8 SEC. 201. THE PREVENTION AND PUBLIC HEALTH FUND.

9 Subsection (b) of section 4002 of the Patient Protec-  
10 tion and Affordable Care Act (42 U.S.C. 300u–11) is  
11 amended by striking paragraphs (3) through (8).

### 12 SEC. 202. SUPPORT FOR STATE RESPONSE TO OPIOID CRI- 13 SIS.

14 There is authorized to be appropriated, and is appro-  
15 priated, out of monies in the Treasury not otherwise obli-  
16 gated, \$2,000,000,000 for fiscal year 2018, to the Sec-  
17 retary of Health and Human Services to provide grants  
18 to States to support substance use disorder treatment and  
19 recovery support services for individuals with mental or  
20 substance use disorders. Funds appropriated under this  
21 section shall remain available until expended.

### 22 SEC. 203. COMMUNITY HEALTH CENTER PROGRAM.

23 Effective as if included in the enactment of the Medi-  
24 care Access and CHIP Reauthorization Act of 2015 (Pub-  
25 lic Law 114–10, 129 Stat. 87), paragraph (1) of section

1 221(a) of such Act is amended by inserting “, and an ad-  
2 ditional \$422,000,000 for fiscal year 2017” after “2017”.

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

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

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

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

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

22 “(5) MEDICAL LOSS RATIO DETERMINED BY  
23 THE STATE.—For plan years beginning on or after  
24 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. WAIVERS FOR STATE INNOVATION.**

14          (a) IN GENERAL.—Section 1332 of the Patient Pro-  
15          tection and Affordable Care Act (42 U.S.C. 18052) is  
16          amended—

17                  (1) in subsection (a)—

18                          (A) in paragraph (1)—

19                                  (i) in subparagraph (B)—

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

22    “(i) a description of how the State  
23    plan meeting the requirements of a waiver  
24    under this section would, with respect to

1 health insurance coverage within the  
2 State—

3 “(I) take the place of the require-  
4 ments described in paragraph (2) that  
5 are waived; and

6 “(II) provide for alternative  
7 means of, and requirements for, in-  
8 creasing access to comprehensive cov-  
9 erage, reducing average premiums,  
10 and increasing enrollment; and”;

11 (II) in clause (ii), by striking  
12 “that is budget neutral for the Fed-  
13 eral Government” and inserting “,  
14 demonstrating that the State plan  
15 does not increase the Federal deficit”;  
16 and

17 (ii) in subparagraph (C), by striking  
18 “the law” and inserting “a law or has in  
19 effect a certification”;

20 (B) in paragraph (3)—

21 (i) by adding after the second sen-  
22 tence the following: “A State may request  
23 that all of, or any portion of, such aggre-  
24 gate amount of such credits or reductions



1 be paid to the State as described in the  
2 first sentence.”;

3 (ii) in the paragraph heading, by  
4 striking “PASS THROUGH OF FUNDING”  
5 and inserting “FUNDING”;

6 (iii) by striking “With respect” and  
7 inserting the following:

8 “(A) PASS THROUGH OF FUNDING.—With  
9 respect”; and

10 (iv) by adding at the end the fol-  
11 lowing:

12 “(B) ADDITIONAL FUNDING.—There is au-  
13 thorized to be appropriated, and is appro-  
14 priated, to the Secretary of Health and Human  
15 Services, out of monies in the Treasury not oth-  
16 erwise obligated, \$2,000,000,000 for fiscal year  
17 2017, to remain available until the end of fiscal  
18 year 2019, to provide grants to States for pur-  
19 poses of submitting an application for a waiver  
20 granted under this section and implementing  
21 the State plan under such waiver.

22 “(C) AUTHORITY TO USE LONG-TERM  
23 STATE INNOVATION AND STABILITY ALLOT-  
24 MENT.—If the State has an application for an  
25 allotment under section 2105(i) of the Social

1 Security Act for the plan year, the State may  
2 use the funds available under the State’s allot-  
3 ment for the plan year to carry out the State  
4 plan under this section, so long as such use is  
5 consistent with the requirements of paragraphs  
6 (1) and (7) of section 2105(i) of such Act  
7 (other than paragraph (1)(B) of such section).  
8 Any funds used to carry out a State plan under  
9 this subparagraph shall not be considered in de-  
10 termining whether the State plan increases the  
11 Federal deficit.”; and

12 (C) in paragraph (4), by adding at the end  
13 the following:

14 “(D) EXPEDITED PROCESS.—The Sec-  
15 retary shall establish an expedited application  
16 and approval process that may be used if the  
17 Secretary determines that such expedited proc-  
18 ess is necessary to respond to an urgent or  
19 emergency situation with respect to health in-  
20 surance coverage within a State.”;

21 (2) in subsection (b)—

22 (A) in paragraph (1)—

23 (i) in the matter preceding subpara-  
24 graph (A)—

1 (I) by striking “may” and insert-  
2 ing “shall”; and

3 (II) by striking “only if” and in-  
4 serting “unless”; and

5 (ii) by striking “plan—” and all that  
6 follows through the period at the end of  
7 subparagraph (D) and inserting “plan will  
8 increase the Federal deficit, not taking  
9 into account any amounts received through  
10 a grant under subsection (a)(3)(B).”;

11 (B) in paragraph (2)—

12 (i) in the paragraph heading, by in-  
13 serting “OR CERTIFY” after “LAW”;

14 (ii) in subparagraph (A), by inserting  
15 before the period “, and a certification de-  
16 scribed in this paragraph is a document,  
17 signed by the Governor, and the State in-  
18 surance commissioner, of the State, that  
19 provides authority for State actions under  
20 a waiver under this section, including the  
21 implementation of the State plan under  
22 subsection (a)(1)(B)”;

23 (iii) in subparagraph (B)—

24 (I) in the subparagraph heading,  
25 by striking “OF OPT OUT”; and

1 (II) by striking “ may repeal a  
2 law” and all that follows through the  
3 period at the end and inserting the  
4 following: “may terminate the author-  
5 ity provided under the waiver with re-  
6 spect to the State by—

7 “(i) repealing a law described in sub-  
8 paragraph (A); or

9 “(ii) terminating a certification de-  
10 scribed in subparagraph (A), through a  
11 certification for such termination signed by  
12 the Governor, and the State insurance  
13 commissioner, of the State.”;

14 (3) in subsection (d)(2)(B), by striking “and  
15 the reasons therefore” and inserting “and the rea-  
16 sons therefore, and provide the data on which such  
17 determination was made”; and

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

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

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

1           “(3) may not be cancelled by the Secretary be-  
2           fore the expiration of the 8-year period (including  
3           any renewal period under paragraph (2)).”.

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

7           (1) In the case of a State for which a waiver  
8           under such section was granted prior to the date of  
9           enactment of this Act, such section 1332, as in ef-  
10          fect on the day before the date of enactment of this  
11          Act shall apply to the waiver and State plan.

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

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

1 **SEC. 207. FUNDING FOR COST-SHARING PAYMENTS.**

2       There is appropriated to the Secretary of Health and  
3 Human Services, out of any money in the Treasury not  
4 otherwise appropriated, such sums as may be necessary  
5 for payments for cost-sharing reductions authorized by the  
6 Patient Protection and Affordable Care Act (including ad-  
7 justments to any prior obligations for such payments) for  
8 the period beginning on the date of enactment of this Act  
9 and ending on December 31, 2019. Notwithstanding any  
10 other provision of this Act, payments and other actions  
11 for adjustments to any obligations incurred for plan years  
12 2018 and 2019 may be made through December 31, 2020.

13 **SEC. 208. REPEAL OF COST-SHARING SUBSIDY PROGRAM.**

14       (a) **IN GENERAL.**—Section 1402 of the Patient Pro-  
15 tection and Affordable Care Act is repealed.

16       (b) **EFFECTIVE DATE.**—The repeal made by sub-  
17 section (a) shall apply to cost-sharing reductions (and pay-  
18 ments to issuers for such reductions) for plan years begin-  
19 ning after December 31, 2019.