[DISCUSSION DRAFT]

115TH CONGRESS
1ST SESSION

H. R. _____

To provide for reconciliation pursuant to section 2002 of the concurrent resolution on the budget for fiscal year 2017.

IN THE HOUSE OF REPRESENTATIVES

M__. _____ introduced the following bill; which was referred to the Committee on _____

A BILL

To provide for reconciliation pursuant to section 2002 of the concurrent resolution on the budget for fiscal year 2017.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "_____ Act of 2017".

TITLE I—ENERGY AND COMMERCE

SEC. 101. THE PREVENTION AND PUBLIC HEALTH FUND.

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

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

(2) in paragraph (3)—

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

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

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

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FUNDS.—Of the funds made available by such section 4002, the unobligated balance at the end of fiscal year 2018 is rescinded.

SEC. 102. COMMUNITY HEALTH CENTER PROGRAM.

Section 10503(b)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(1)) is amended—[*Note: Hyde language to be included.*]

(1) in subparagraph (D), by striking "and" at the end; and

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

"(F) $285,000,000 for fiscal year 2018; and".

SEC. 103. REPEAL OF MEDICAID PROVISIONS.

The Social Security Act is amended—

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

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

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

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

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

tion 1902(a)(10)(A) before January 1, 2020, section 1902(a)(10)(A)(i)(IX),".

SEC. 104. REPEAL OF MEDICAID EXPANSION.

(a) IN GENERAL.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)) is amended—

(1) in clause (i)(VIII), by inserting "at the option of a State," after "January 1, 2014,"; and

(2) in clause (ii)(XX), by inserting "and ending December 31, 2019," after "2014,".

(b) TERMINATION OF EFMAP FOR NEW ACA EXPANSION ENROLLEES.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (y)(1), in the matter preceding subparagraph (A), by striking "with respect to" and all that follows through "shall be" and inserting "with respect to amounts expended before January 1, 2020, by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) who are enrolled under the State plan (or a waiver of the plan) before such date and with respect to amounts expended after such date by such State for medical assistance for individuals described in such subclause who were enrolled under such plan (or waiver of such plan) as

of December 31, 2019, and who do not have a break in eligibility for medical assistance under such State plan (or waiver) for more than one month after such date, shall be"; and

(2) in subsection (z)(2)—

(A) in subparagraph (A), by striking "medical assistance for individuals" and all that follows through "shall be" and inserting "amounts expended before January 1, 2020, by such State for medical assistance for individuals described in section 1902(a)(10)(A)(i)(VIII) who are nonpregnant childless adults with respect to whom the State may require enrollment in benchmark coverage under section 1937 and who are enrolled under the State plan (or a waiver of the plan) before such date and with respect to amounts expended after such date by such State for medical assistance for individuals described in such section, who are nonpregnant childless adults with respect to whom the State may require enrollment in benchmark coverage under section 1937, who were enrolled under such plan (or waiver of such plan) as of December 31, 2019, and who do not have a break in eligibility for medical assistance under such

State plan (or waiver) for more than one month after such date, shall be" ; and

(B) in subparagraph (B)(ii)—

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

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

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

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

SEC. 105. REPEAL OF DSH ALLOTMENT REDUCTIONS.

Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended by striking paragraphs (7) and (8).

SEC. 106. REPEAL OF COST-SHARING SUBSIDY.

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

(b) EFFECTIVE DATE.—The repeal in subsection (a) shall take effect on December 31, [2019].

SEC. 107. PER CAPITA-BASED CAP ON MEDICAID PAYMENTS FOR MEDICAL ASSISTANCE.

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

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

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

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

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

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

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

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

year. In this section, the term 'State' means only the 50 States and the District of Columbia.

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

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

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

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

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

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

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

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

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

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

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

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

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

State and fiscal year otherwise included in such medical assistance expenditures; and

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

"(B) for fiscal year 2019 or a subsequent fiscal year, the amount of the medical assistance expenditures (as defined in paragraph (2)) for the State and fiscal year that is attributable to 1903A enrollees, reduced by the amount of any excluded expenditures (as defined in paragraph (3)) for the State and fiscal year otherwise included in such medical assistance expenditures.

"(2) MEDICAL ASSISTANCE EXPENDITURES.—In this section, the term 'medical assistance expenditures' means, for a State and fiscal year, the medical assistance payments as reported by medical service category on the Form CMS-64 quarterly expense report (or successor to such a report form, and including enrollment data and subsequent adjustments to any such report, in this section referred to collectively as a 'CMS-64 report') that directly result from providing medical assistance under the State plan (including under a waiver of the plan) for

which payment is (or may otherwise be) made pursuant to section 1903(a)(1).

"(3) EXCLUDED EXPENDITURES.— In this section, the term 'excluded expenditures' means, for a State and fiscal year, expenditures under the State plan (or under a waiver of such plan) that are attributable to any of the following (which shall not be construed as including payments made with respect to the program under section 1928 or payments attributable to administrative expenditures for which payments are made under section 1903(a) (other than under paragraph (1) of such section)):

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

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

"(4) 1903A FY 16 POPULATION PERCENTAGE.— In this subsection, the term '1903A FY16 population percentage' means, for a State, the Secretary's calculation of the percentage of the actual medical assistance expenditures, as reported by the State on the CMS–64 reports for calendar quarters

in fiscal year 2016, that are attributable to 1903A enrollees (as defined in subsection (e)(1)).

"(c) TARGET TOTAL MEDICAL ASSISTANCE EXPENDITURES.—

"(1) CALCULATION.—In this section, the term 'target total medical assistance expenditures' means, for a State for a fiscal year, the sum of the products, for each of the 1903A enrollee categories (as defined in subsection (e)(2)), of—

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

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

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

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

"(B) the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from September of 2019 to September of the fiscal year involved plus one percentage point.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(I) is not made under section 1923;

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

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

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

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

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

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

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

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

"(i) the amount calculated under subparagraph (A) for the State, increased by the non-DSH supplemental payment percentage for the State (as calculated under subparagraph (C)); divided by

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

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

"(A) the product of—

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

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

"(B) the amount of the adjusted total medical assistance expenditures for the State for fiscal year 2019, as calculated under paragraph (3)(A).

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

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

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

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

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

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

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

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

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

"(iv) is entitled to medical assistance under this title and for whom the State is providing a payment or subsidy to an em-

ployer for coverage of the individual under a group health plan pursuant to section 1906 or section 1906A (or pursuant to a waiver that provides only comparable benefits).

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

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

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

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

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

"(E) OTHER NONELDERLY, NONDISABLED, NONEXPANSION ADULTS.—A category of 1903A enrollees who are not described in any previous subparagraph.

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

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

"(f) SPECIAL PAYMENT RULES.—

"(1) APPLICATION IN CASE OF WAIVER.—In the case of a State with a waiver approved under section 1115, this section shall apply to medical assistance expenditures and medical assistance payments under the waiver in the same manner as if such expenditures and payments had been made under a State

plan under title XIX and the limitations on expenditures under this section shall supersede any other payment limitations or provisions (including limitations based on a per capita limitation) otherwise applicable under such a waiver.

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

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

“(A) the Secretary shall calculate and apply subsections (a) through (e) with respect

to the State as if all 1903A enrollee categories for which such expenditure and enrollee data were not satisfactorily submitted were a single 1903A enrollee category; and

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

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

"(h) REQUIRED REPORTING AND AUDITING OF CMS–64 DATA; TRANSITIONAL INCREASE IN FEDERAL MATCHING PERCENTAGE FOR CERTAIN ADMINISTRATIVE EXPENSES.—

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

"(2) AUDITING.—The Secretary shall conduct for each State an audit of the number of individuals and expenditures reported through the CMS–64 report for fiscal year 2016, fiscal year 2019, and each subsequent fiscal year, which audit may be con-

ducted on a representative sample (as determined by the Secretary).

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

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

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

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

[(b) CONFORMING AMENDMENTS.—[*Review with CMS any conforming amendments required.*]]

SEC. 108. FEDERAL PAYMENTS TO STATES.

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

(b) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

(B) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act in fiscal year 2014 made directly to the entity and to any affiliates, subsidiaries, successors, or

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

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

SEC. 109. FINANCIAL ASSISTANCE FOR STATES FOR FUNDING THE NEEDS OF CERTAIN INDIVIDUALS.

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

"TITLE XXII—STATE INNOVATION GRANTS AND STABILITY PROGRAM

"SEC. 2201. ESTABLISHMENT OF PROGRAM.

"There is hereby established the 'State Innovation Grants and Stability Program' to be administered by the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as the 'Administrator'), to provide funding, in accordance with this section, to the 50 States and the District of Columbia (each referred to in this section as a 'State') during the period

beginning on January 1, 2018, and ending on December 31, 2026, for the purposes described in section 2202.

"SEC. 2202. USE OF FUNDS.

"A State may use the funds allocated to the State under this title for any of the following purposes:

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

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

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

"(4) Promoting participation in the State health insurance market and increasing health insurance options available through such market.

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

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

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

"SEC. 2203. STATE ELIGIBILITY AND APPROVAL.

"(a) IN GENERAL.—To be eligible for an allocation of funds under this title for a year beginning with 2020, a State shall submit to the Administrator an application at such time (but not later than [June 30] of the [previous] year) and in such form and manner as specified by the Administrator and containing—

"(1) a description of how the funds will be used for one or more of the purposes described in section 2202;

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

"(3) such other information as the Administrator may require.

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

"(c) ONE-TIME APPLICATION.—If an application of a State is approved for a year, with respect to a purpose described in section 2202, such application shall be treated as approved, with respect to such purpose, for each subsequent year through December 31, 2026.

"(d) TREATMENT AS A STATE HEALTH CARE PROGRAM.—Any program receiving funds from an allocation to a State under this title, shall be considered to be a

'State health care program' for purposes of sections 1128, 1128A, and 1128B.

"SEC. 2204. ALLOCATIONS.

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

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

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

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

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

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

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

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

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

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

"(b) ALLOCATIONS.—

"(1) FOR TEMPORARY STATE FISCAL RELIEF FOR 2018 AND 2019.—

"(A) PAYMENT.—

"(i) IN GENERAL.—From amounts appropriated under subsection (a) for 2018 or 2019, the Administrator shall, with respect to a State and not later than the

date specified under clause (ii) for such year, pay such State the amount determined for such State and year under subparagraph (B).

"(ii) SPECIFIED DATE.—For purposes of clause (i), the date specified in this clause is—

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

"(II) for 2019, January 1, 2019.

"(B) ALLOCATIONS BASED ON RELATIVE HEALTH COSTS.—

"(i) IN GENERAL.—Subject to (vi)(II), the amount appropriated under subsection (a) for each of 2018 and 2019 shall be used to allocate to each State for such year an amount equal to the relative health cost proportion amount described in clause (ii) for the State and year.

"(ii) RELATIVE HEALTH COST PROPORTION AMOUNT.—The relative health cost proportion amount described in this clause for a State and year is the product of—

"(I) the amount described in subsection (a) for the year; and

"(II) the relative State health cost proportion (as defined in clause (iii)) for such State and year;

adjusted in accordance with clause (vi)(I).

"(iii) RELATIVE STATE HEALTH COST PROPORTION DEFINED.—For purposes of clause (ii)(II), the term 'relative State health cost proportion' means, with respect to a State and year, the amount equal to the quotient of—

"(I) the State health cost (determined in accordance with clause (iv)) for the year; and

"(II) the total health costs of all States (determined in accordance with clause (v)) for the year.

"(iv) STATE HEALTH COST.—For purposes of clause (iii), the State health cost for a State shall be—

"(I) for 2018, the amount equal to the product of—

"(aa) the estimated number of individuals who were eligible to

enroll through an Exchange for residents of such State under section 1311 or 1321 of the Patient Protection and Affordable Care Act for plan year 2016; and

"(bb) the amount by which the average cost of premiums for plan year 2016 for health plans in such State exceeds the national average cost of premiums for such year for health plans; and

"(II) for 2019, the amount equal to the product of——

"(aa) the estimated number of individuals who were eligible to enroll through an Exchange for residents of such State under section 1311 or 1321 of the Patient Protection and Affordable Care Act for plan year 2017; and

"(bb) the amount by which the average cost of premiums for plan year 2017 for health plans in such State exceeds the na-

tional average cost of premiums for such year for health plans.

In estimating the number of individuals enrolling through an Exchange for purposes of this clause for a year, the Administrator shall not take into account any individual who is eligible for medical assistance under title XIX (except, in the case of a State that has elected to provide under its State plan (or a waiver of such plan) medical assistance to individuals described in section 1902(a)(10)(A)(i)(VIII), individuals described in such section who are eligible to receive such medical assistance under such State plan (or such waiver)), an alien unlawfully present in the United States, and an individual who is eligible for employer health coverage.

"(v) TOTAL HEALTH COSTS.—For purposes of clause (iii), the total health costs for all States for a year shall be the amount equal to the sum of each amount determined under clause (iv) for each State for such year.

"(vi) MINIMUM PAYMENT.—

"(I) PRO RATA ADJUSTMENTS.—The Administrator shall adjust on a pro rata basis the amount determined under clause (ii) for a State to the extent necessary to comply with the requirement of subclause (II).

"(II) MINIMUM AMOUNT.—The requirement of this subclause is that no State shall receive a payment under this paragraph for a year that is less than [1/2 of 1 percent of the amount appropriated for such year under subsection (a)].

"(C) CERTIFICATION.—In order to receive an allotment under this paragraph for a year, a State shall provide the Administrator with a certification that the State's proposed uses of the funds are consistent with section 2202 and subsection (d)(2) by not later than the last day of such year.

"(2) FOR 2020 THROUGH 2026.—In the case of a State with an application approved under section 2203 with respect to a year after 2019, subject to subsection (d), the Administrator shall allocate to such State, from amounts appropriated for such

year under subsection (a) and in accordance with an allocation methodology specified by the Administrator which takes into consideration the percentage of residents of such State with income that is below [300]/[250]/[138] percent of the poverty line applicable to the size of the family involved as well as the number of residents of such State who are individuals without health insurance, such amount as specified by the Administrator with respect to such State and application and year.

"(3) ANNUAL DISTRIBUTION OF PREVIOUS YEAR'S REMAINING FUNDS.— In carrying out paragraph (2), with respect to a year (beginning with 2020), the Administrator shall, not later than March 31 of such year—

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

"(B) if the Administrator determines that any funds were not so allocated for such previous year, allocate such remaining funds, in accordance with the allocation methodology specified pursuant to paragraph (1), to States that have submitted an application approved under

section 2023 for such previous year for any purpose for which such an application was approved.

"(c) AVAILABILITY.—Amounts appropriated under subsection (a) for a year and allocated to States in accordance with this section shall remain available for expenditure through December 31, 2026.

"(d) CONDITIONS FOR AND LIMITATIONS ON RECEIPT OF FUNDS.—The Secretary may not make an allocation under this subsection to a State, with respect to an application approved under section 2203—

"(1) if the State does not agree that the State will make available non-Federal contributions towards each purpose for which such application was approved in an amount equal to—

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

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

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

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

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

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

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

"(2) if such an allocation would not be permitted under subsection (c)(7) of section 2105 if such allocation were payment made under such section.".

SEC. 110. CONTINUOUS HEALTH INSURANCE COVERAGE INCENTIVE.

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

(1) in section 2701(a)(1)(B), by striking "such rate" and inserting "subject to section 2711, such rate";

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

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

"SEC. 2711. ENCOURAGING CONTINUOUS HEALTH INSURANCE COVERAGE.

"(a) PENALTY APPLIED.—

"(1) IN GENERAL.—Notwithstanding section 2701, subject to the succeeding provisions of this section, a health insurance issuer offering health insurance coverage in the individual or small group market shall, in the case of an individual who is an applicable policyholder of such coverage with respect to an enforcement period applicable to enrollments for a plan year beginning with plan year 2019 (or, in the case of enrollments during a special enrollment period, beginning with plan year 2018), increase the monthly premium rate otherwise applicable to such individual for such coverage during each month of such period, by an amount determined under paragraph (2).

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

amount that is equal to 30 percent of the monthly premium rate otherwise applicable to such applicable policyholder for such coverage during such month.

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

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

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

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

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

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

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

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

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

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

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

"(c) CERTIFICATIONS OF CREDITABLE COVERAGE IN CASE OF COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of coverage provided by any governmental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall provide, in accordance with regulations promulgated to carry out this section, for certifications of creditable coverage required by this section.".

SEC. 111. PERMITTING STATES TO DETERMINE ESSENTIAL HEALTH BENEFITS.

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

(1) in subsection (a)(1), by inserting "(or, for health plans offered for plan years beginning with plan year 2020, defined by the State in which such a health plan is offered)" after "subsection (b)"; and

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

"(6) SUNSET.—The provisions of this subsection shall not apply after December 31, 2019, and after such date any reference [under this sec-

tion, section 1311, or section 1331] to essential health benefits under this subsection shall be treated as a reference to essential health benefits applied under subsection (a).".

SEC. 112. OTHER MARKET REFORMS.

(a) CHANGE IN PERMISSIBLE AGE VARIATION IN HEALTH INSURANCE PREMIUM RATES.—Section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)(iii)), as inserted by section 1201(4) of Public Law 111–148, is amended by inserting after "3 to 1 for adults (consistent with section 2707(c))" the following: "or, for plan years beginning on or after January 1, 2018, 5 to 1 for adults (consistent with section 2707(c)) or such other ratio for adults (consistent with section 2707(c)) as the State involved may provide".

(b) REQUIRING VERIFICATION FOR ELIGIBILITY FOR ENROLLMENT DURING SPECIAL ENROLLMENT PERIODS IN PPACA INSURANCE PLANS.—Section 1311(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)) is amended by adding at the end the following new paragraph:

"(7) VERIFICATION REQUIREMENT FOR SPECIAL ENROLLMENT PERIODS.—

"(A) IN GENERAL.—The Secretary shall provide that, in the case of a special enrollment

period provided for under paragraph (6)(C) that is with respect to a plan year that begins on or after January 1, 2018, qualified health plans offered through an Exchange may not make coverage effective with respect to an individual enrolling during such period until the Exchange verifies, through an approved verification process described in subparagraph (B), that the individual, with respect to such Exchange, is a qualified individual who is eligible to enroll during such period.

"(B) APPROVED VERIFICATION PROCESS DESCRIBED.—For purposes of subparagraph (A), an approved verification process described in this subparagraph is a process specified by the Secretary through interim final rulemaking that requires an individual described in subparagraph (A) seeking to enroll in a qualified health plan described in such subparagraph to submit to the Exchange such documents as the Secretary determines are necessary in order for the Exchange to verify that the individual, with respect to such Exchange, is a qualified individual who is eligible to enroll during a period described in such subparagraph. To the extent

practicable, such process shall be similar to the review and assessment process pertaining to special enrollment periods described at 81 Fed. Reg. 12274 in the final rule entitled 'Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017', published at 81 Fed. Reg. 12203 (March 8, 2016).".

(c) EXTENDING OPTION TO CONTINUE PRE-ACA COVERAGE.—

(1) IN GENERAL.—A health insurance issuer that had in effect health insurance coverage in the individual market as of January 1, 2013, and has continued such coverage through January 1, 2017, under CCIIO guidance (as defined in paragraph (3)) may renew and continue to offer such coverage for sale on and after the date of the enactment of this Act in the individual market outside of an Exchange established under section 1311 or 1321 of such Act (42 U.S.C. 18031, 18041).

(2) TREATMENT AS GRANDFATHERED HEALTH PLAN IN SATISFACTION OF MINIMUM ESSENTIAL COVERAGE.—Health insurance coverage described in paragraph (1) shall be treated as a grandfathered

health plan for purposes of section 5000A of the Internal Revenue Code of 1986.

(3) CCIIO GUIDANCE DEFINED.—In this section, the term "CCIIO guidance" means the letter issued by the Centers for Medicare & Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the small group and individual health insurance markets, as subsequently extended and modified (including by a communication entitled "Insurance Standards Bulletin Series—INFORMATION—Extension of Transitional Policy through Calendar Year 2017" issued on February 29, 2016, by the Director of the Center for Consumer Information & Insurance Oversight of such Centers).

(d) PERMITTING CONTINUED OFFERING OF PRE-ACA HEALTH INSURANCE COVERAGE IN THE SMALL GROUP MARKET.—

(1) IN GENERAL.—A health insurance issuer that has in effect health insurance coverage in the small group market on any date during 2013 may offer such coverage for sale on or after the date of the enactment of this Act in such market outside of an Exchange established under section 1311 or 1321

of such Act (42 U.S.C. 18031, 18041). Such a group health plan shall not be treated as not complying with the requirements of such Act (or the amendments made by such Acts) insofar as it provides health benefits through health insurance coverage that is permitted under the previous sentence.

(2) TREATMENT AS GRANDFATHERED HEALTH PLAN IN SATISFACTION OF MINIMUM ESSENTIAL COVERAGE.—Health insurance coverage described in paragraph (1) shall be treated as a grandfathered health plan for purposes of section 5000A of the Internal Revenue Code of 1986.

(3) SMALL GROUP MARKET DEFINED.—In this section, the term "small group market" has the meaning given such term in section 2791(e)(5) of the Public Health Service Act (42 U.S.C. 300gg–91(e)(5)).

TITLE II—WAYS AND MEANS

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

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

"(iii) NONAPPLICABILITY OF LIMITATION.—This subparagraph shall not apply

to taxable years ending after December 31, 2017, and before January 1, 2020.".

[SEC. 202. ADDITIONAL MODIFICATIONS TO PREMIUM TAX CREDIT.

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

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

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

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

["(i) is a grandfathered health plan, or]

["(ii) includes coverage for abortions (other than any abortion or treatment described in section 307 or 308 of title 1, United States Code).".]

[(2) CONFORMING AMENDMENT RELATED TO SEPARATE ABORTION COVERAGE.—Section

36B(c)(3) of such Code is amended by adding at the end the following new subparagraph:]

[“(C) SEPARATE ABORTION COVERAGE OR PLAN ALLOWED.—]

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

[“(ii) OPTION TO OFFER COVERAGE OR PLAN.—Nothing in subparagraph (A) shall restrict any non-Federal health insurance issuer offering a health plan from offering separate coverage for abortions described in such subparagraph, or a plan that includes such abortions, so long as premiums for such separate coverage or plan are not paid for with any amount attributable to the credit allowed under this section (or the amount of any advance pay-

ment of the credit under section 1412 of the Patient Protection and Affordable Care Act).".]

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

[(A) NONRESIDENT ALIENS INELIGIBLE FOR CREDIT .—Section 36B(c)(1) of such Code is amended by adding at the end the following new subparagraph:]

["(E) DENIAL OF CREDIT TO NON-RESIDENT ALIENS.—No credit shall be allowed under this section to any taxpayer unless such taxpayer (in the case of a joint return, either spouse) is a citizen or national of the United States or an alien lawfully present in the United States.".]

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

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

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

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

["(A) the premiums paid with respect to such coverage,]

["(B) the months during which such coverage is provided to the individual, and]

["(C) such other information as the Secretary may prescribe.]

This paragraph shall not apply with respect to coverage provided for any month beginning after December 31, 2019.".]

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

[“(A) APPLICABLE PERCENTAGE.—]

[“(i) IN GENERAL.—The applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial percentage to the final percentage specified in such table for such income tier with respect to a taxpayer of the age involved: [percentages in the following table need to be increased to the percentages that are intended to apply for 2017]]

“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		Age 60-64	
	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %
Up to 133%	2	2	2	2	2	2	2	2	2	2
133%-150%	3	4	3	4	3	4	3	4	3	4
150%-200%	4	4.3	4	5.3	4	6.3	4	7.3	4	8.3
200%-250%	4.3	4.3	5.3	5.9	6.3	8.05	7.3	9	8.3	10
250%-300%	4.3	4.3	5.9	5.9	8.05	8.35	9	10.5	10	11.5
399%-400%	4.3	4.3	5.9	5.9	8.35	8.35	10.5	10.5	11.5	11.5

[“(ii) AGE DETERMINATIONS.—]

[“(I) IN GENERAL.—For purposes of clause (i), the age of the taxpayer taken into account under clause (i) with respect to any taxable year is

the age attained by such taxpayer before the close of such taxable year.]

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

[“(iii) INDEXING.—In the case of taxable years beginning after 2017,the initial and final percentages under clause (i) (as in effect for the preceding calendar year after application of this clause) shall be adjusted to reflect—]

[“(I) the excess (if any) of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year, and]

[“(II) except as provided in clause (iv), the excess (if any) of the rate of premium growth for the preceding calendar year over the rate of growth in the consumer price index for the preceding calendar year.]

[“(iv) FAILSAFE.—Clause (iii)(II) shall apply for any calendar year only if

the aggregate amount of premium tax credits under this section and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act for the preceding calendar year exceeds an amount equal to 0.504 percent of the gross domestic product for the preceding calendar year.".]

[(c) EFFECTIVE DATE.—]

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

[(2) ADVANCE PAYMENT NOT APPLICABLE TO OFF-EXCHANGE COVERAGE.—The amendment made by subsection (a)(3)(B) shall take effect on January 1, 2018.]

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

SEC. 203. PREMIUM TAX CREDIT.

(a) REPEAL OF PREMIUM TAX CREDIT.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking section 36B.

(b) REPEAL OF ELIGIBILITY DETERMINATIONS.—The following sections of the Patient Protection and Affordable Care Act are repealed:

[(1) Section 1411 (other than subsection (i), the last sentence of subsection (e)(4)(A)(ii), and such provisions of such section solely to the extent related to the application of the last sentence of subsection (e)(4)(A)(ii)).]

(2) Section 1412.

(c) PROTECTING AMERICANS BY REPEAL OF DISCLOSURE AUTHORITY TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.—Paragraph (21) of section 6103(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

"(D) TERMINATION.—No disclosure may be made under this paragraph after December 31, 2019.".

(d) EFFECTIVE DATES.—

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

(2) OTHER PROVISIONS.—The amendments made by subsections (b) and (c) shall take effect on January 1, 2020.

SEC. 204. SMALL BUSINESS TAX CREDIT.

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

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

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2019.

SEC. 205. INDIVIDUAL MANDATE.

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

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

(2) in paragraph (3)—

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

(B) by striking subparagraph (D).

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

SEC. 206. EMPLOYER MANDATE.

(a) IN GENERAL.—

(1) Paragraph (1) of section 4980H(c) of the Internal Revenue Code of 1986 is amended by in-

serting "($0 in the case of months beginning after December 31, 2015)" after "$2,000".

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

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

SEC. 207. REPEAL OF THE TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by striking section 4980I.

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

SEC. 208. REPEAL OF TAX ON OVER-THE-COUNTER MEDICATIONS.

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

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

ed by striking "Such term" and all that follows through the period.

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of the Internal Revenue Code of 1986 is amended by striking subsection (f) and by redesignating subsection (g) as subsection (f).

(d) EFFECTIVE DATES.—

(1) DISTRIBUTIONS FROM SAVINGS ACCOUNTS.—The amendments made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2016.

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

SEC. 209. REPEAL OF INCREASE OF TAX ON HEALTH SAVINGS ACCOUNTS.

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

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

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

SEC. 210. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO FLEXIBLE SPENDING ACCOUNTS.

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

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

SEC. 211. REPEAL OF TAX ON PRESCRIPTION MEDICATIONS.

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

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

SEC. 212. REPEAL OF MEDICAL DEVICE EXCISE TAX.

Section 4191 is amended by adding at the end the following new subsection:

"(d) APPLICABILITY.—The tax imposed under subsection (a) shall not apply to sales after December 31, 2017.".

SEC. 213. REPEAL OF HEALTH INSURANCE TAX.

Subsection (j) of section 9010 of the Patient Protection and Affordable Care Act is amended by striking ", and" at the end of paragraph (1) and all that follows through "2017".

SEC. 214. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.

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

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

SEC. 215. REPEAL OF CHRONIC CARE TAX.

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

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

SEC. 216. REPEAL OF MEDICARE TAX INCREASE.

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

"(b) HOSPITAL INSURANCE.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on the income of every individual a tax equal to 1.45 percent of the wages (as defined in section 3121(a)) received by such individual with respect to employment (as defined in section 3121(b).".

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

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

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received after, and taxable years beginning after, December 31, 2016. [confirm this date]

SEC. 217. REPEAL OF TANNING TAX.

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

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services performed after [December 31, 2016].

SEC. 218. REPEAL OF NET INVESTMENT TAX.

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

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

SEC. 219. REMUNERATION.

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

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

SEC. 220. ECONOMIC SUBSTANCE DOCTRINE.

(a) IN GENERAL.—Subsection (o) of section 7701 of the Internal Revenue Code of 1986 is repealed.

(b) PENALTY FOR UNDERPAYMENTS.—Paragraph (6) of section 6662(b) of the Internal Revenue Code of 1986 is repealed.

(c) INCREASED PENALTY FOR NONDISCLOSED TRANSACTIONS.—Subsection (i) of section 6662 of the Internal Revenue Code of 1986 is repealed.

(d) REASONABLE CAUSE EXCEPTION FOR UNDERPAYMENTS.—Paragraph (2) of section 6664(c) of the Internal Revenue Code of 1986 is repealed.

(e) REASONABLE CAUSE EXCEPTION FOR NONDISCLOSED TRANSACTIONS.—Paragraph (2) of section 6664(d) of the Internal Revenue Code of 1986 is repealed.

(f) ERRONEOUS CLAIM FOR REFUND OR CREDIT.—Subsection (c) of section 6676 of the Internal Revenue Code of 1986 is repealed.

(g) EFFECTIVE DATE.—The repeals made by this section shall apply to transactions entered into, and to underpayments, understatements, or refunds and credits attributable to transactions entered into, after December 31, 2016.

SEC. 221. REFUNDABLE TAX CREDIT FOR HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 36B the following new section:

"SEC. 36C. HEALTH INSURANCE COVERAGE.

"(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year the lesser of—

"(1) the sum of the monthly credit amounts determined under subsection (b) with respect to the taxpayer and the taxpayer's qualifying family members for eligible coverage months beginning during the taxable year, or

"(2) the amount paid by the taxpayer for eligible health insurance for the taxpayer and the taxpayer's qualifying family members for eligible coverage months beginning during the taxable year.

"(b) MONTHLY CREDIT AMOUNTS.—

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

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

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

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

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

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

"(2) LIMITATIONS.—

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

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

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

"(1) is covered by eligible health insurance,

"(2) is not eligible for other specified coverage,

"(3) is either—

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

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

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

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

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

"(2) any dependent of the taxpayer, and

"(3) with respect to any eligible coverage month, any child (as defined in section 152(f)(1)) of the taxpayer who as of the end of the taxable year has not attained age 27 if the taxpayer paid the premium for such child's eligible health insurance with respect to such month.

"(e) ELIGIBLE HEALTH INSURANCE.—For purposes of this section, the term 'eligible health insurance' means any health insurance coverage (as defined in section 9832(b)) if—

"(1) such coverage is either—

"(A) offered in the individual market within a State, or

"(B) is unsubsidized COBRA continuation coverage,

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

"(3) such coverage does not include coverage for abortions (other than any abortion or treatment described in section 307 or 308 of title 1, United States Code).

"(f) OTHER SPECIFIED COVERAGE.—For purposes of this section—

"(1) IN GENERAL.—The term 'other specified coverage' means any of the following:

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

"(B) Coverage under the Medicare program under part A of title XVIII of the Social Security Act.

"(C) Coverage under the Medicaid program under title XIX of the Social Security Act.

"(D) Coverage under the CHIP program under title XXI of the Social Security Act.

"(E) Medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program.

"(F) Coverage under a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary of the Treasury.

"(G) Coverage under a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers).

"(H) Coverage under the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103–337; 10 U.S.C. 1587 note).

"(I) Membership in a health care sharing ministry.

"(2) SPECIAL RULE WITH RESPECT TO VETERANS HEALTH PROGRAMS.—In the case of other specified coverage described in paragraph (1)(F), an individual shall not be treated as eligible for such

coverage unless such individual is enrolled in such coverage.

"(g) OTHER DEFINITIONS.—For purposes of this section—

"(1) HEALTH CARE SHARING MINISTRY.—The term 'health care sharing ministry' means an organization—

"(A) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

"(B) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

"(C) members of which retain membership even after they develop a medical condition,

"(D) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

"(E) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

"(2) UNSUBSIDIZED COBRA CONTINUATION COVERAGE.—

"(A) IN GENERAL.—The term 'unsubsidized COBRA continuation coverage' means COBRA continuation coverage no portion of the premiums for which are subsidized by the employer.

"(B) COBRA CONTINUATION COVERAGE.—The term 'COBRA continuation coverage' means continuation coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (other than under section 609), title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986 (other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines), or section 8905a of title 5, United States Code, or under a State program that provides comparable continuation coverage. Such term shall not include

coverage under a health flexible spending arrangement.

"(h) SPECIAL RULES.—

"(1) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, no credit shall be allowed under this section to such taxpayer unless such taxpayer and the taxpayer's spouse file a joint return for such taxable year.

"(2) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual who is a dependent with respect to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

"(3) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—Amounts described in subsection (a)(2) with respect to any month shall not be taken into account in determining the deduction allowed under section 213 except to the extent that such amounts exceed the amount described in subsection (a)(1) with respect to such month.

[“(4) INSURANCE WHICH COVERS OTHER INDIVIDUALS.—For purposes of this section, rules similar to the rules of section 213(d)(6) shall apply with

respect to any contract for eligible health insurance under which amounts are payable for coverage of an individual other than the taxpayer and the taxpayer's qualifying family members.]

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

"(A) the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7529 for months beginning in such taxable year, and

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

"(i) the aggregate amount paid on behalf of such taxpayer under section 7529 for months beginning in such taxable year, over

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

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

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

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

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

for which such arrangement was provided' for '12'.

"(7) SEPARATE ABORTION COVERAGE OR PLAN ALLOWED.—

"(A) OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.—Nothing in subsection (e)(3) shall be construed as prohibiting any individual from purchasing separate coverage for abortions described in such subparagraph, or a health plan that includes such abortions, so long as no credit is allowed under this section with respect to the premiums for such coverage or plan.

"(B) OPTION TO OFFER COVERAGE OR PLAN.—Nothing in subsection (e)(3) shall restrict any non-Federal health insurance issuer offering a health plan from offering separate coverage for abortions described in such clause, or a plan that includes such abortions, so long as premiums for such separate coverage or plan are not paid for with any amount attributable to the credit allowed under this section.

"(8) INFLATION ADJUSTMENT.—

"(A) IN GENERAL.—In the case of any taxable year beginning in a calendar year after

2020, each dollar amount contained in paragraphs (1) and (2)(A) of subsection (b) shall be increased by an amount equal to—

"(i) such dollar amount, multiplied by

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

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

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

"(B) TERMS RELATED TO CPI.—

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

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

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

"(9) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be necessary or appropriate to carry out this section, section 6050W, and section 7529.".

(b) ADVANCE PAYMENT OF CREDIT; EXCESS HEALTH INSURANCE COVERAGE CREDIT PAYABLE TO HEALTH SAVINGS ACCOUNT.—

(1) IN GENERAL.—Chapter 77 of such Code is amended by adding at the end the following:

"SEC. 7529. ADVANCE PAYMENT OF HEALTH INSURANCE COVERAGE CREDIT.

"(a) GENERAL RULE.—Not later than January 1, 2020, the Secretary, in consultation with the Secretary of Health and Human Services, the Secretary of Homeland Security, and the Commissioner of Social Security, shall establish a program for making payments to providers of eligible health insurance on behalf of taxpayers eligible for the credit under section 36C.

"(b) LIMITATION.—The aggregate payments made under this section with respect to any taxpayer, determined as of any time during any calendar year, shall not exceed the monthly credit amounts determined with respect to such taxpayer under section 36C for months during such calendar year which have ended as of such time.

"(c) ADMINISTRATION.—The program for making payments described in subsection (a) shall, to the greatest extent practicable, use the methods and procedures used to administer the programs created under sections 1411 and 1412 of the Patient Protection and Affordable Care Act (as in effect before their repeal) and each entity that is required under such sections (as so in effect) to take any actions under such programs shall, at the request of the Secretary, take such actions to the extent necessary to carry out this section. Except as otherwise provided by the Secretary, for purposes of applying this subsection in the case of eligible health insurance which is not enrolled in through an Exchange established under title I of the Patient Protection and Affordable Care Act, such sections shall be applied by treating references in such sections to an Exchange as references to the issuer of such eligible health insurance.

"(d) DEFINITIONS.—For purposes of this section, terms used in this section which are also used in section

36C shall have the same meaning as when used in section 36C.

"SEC. 7530. EXCESS HEALTH INSURANCE COVERAGE CREDIT PAYABLE TO HEALTH SAVINGS ACCOUNT.

"(a) IN GENERAL.—At the request of an eligible taxpayer, the Secretary shall make a payment to the trustee of the designated health savings account with respect to such taxpayer in an amount equal to the sum of the excesses (if any) described in subsection (c)(2) with respect to months in the taxable year.

"(b) DESIGNATED HEALTH SAVINGS ACCOUNT.—The term 'designated health savings account' means a health savings account of an individual described in subsection (c)(3) which is identified by the eligible taxpayer for purposes of this section.

"(c) ELIGIBLE TAXPAYER.—The term 'eligible taxpayer' means, with respect to any taxable year, any taxpayer if—

"(1) such taxpayer is allowed a credit under section 36C for such taxable year,

"(2) the amount described in paragraph (1) of section 36C(a) exceeds the amount described in paragraph (2) of such section with respect to such taxpayer applied with respect to any month during such taxable year, and

"(3) the taxpayer or one or more of the taxpayer's qualifying family members (as defined in section 36C(d)) were eligible individuals (as defined in section 223(c)(1)) for one or more months during such taxable year.

"(d) CONTRIBUTIONS TREATED AS ROLLOVERS, ETC.—

"(1) IN GENERAL.—Any amount paid the Secretary to a health savings account under this section shall be treated for purposes of this title in the same manner as a rollover contribution described in section 223(f)(5).

"(2) COORDINATION WITH LIMITATION ON ROLLOVERS.—Any amount described in paragraph (1) shall not be taken into account in applying section 223(f)(5)(B) with respect to any other amount and the limitation of section 223(f)(5)(B) shall not apply with respect to the application of paragraph (1).

"(e) FORM AND MANNER OF REQUEST.—The request referred to in subsection (a) shall be made at such time and in such form and manner as the Secretary may provide. To the extent that the Secretary determines feasible, such request may identify more than one designated health savings account (and the amount to be paid to each

such account) provided that the aggregate of such payments with respect to any taxpayer for any taxable year do not exceed the excess described in subsection (e)(2).

"(f) TAXPAYERS WITH SERIOUSLY DELINQUENT TAX DEBT.—In the case of an individual who has a seriously delinquent tax debt (as defined in section 7345(b)) which has not been fully satisfied—

"(1) if such individual is the eligible taxpayer (or, in the case of a joint return, either spouse), the Secretary shall not make any payment under this section with respect to such taxpayer, and

"(2) if such individual is the account beneficiary (as defined in section 223(d)(3)) of any health savings account, the Secretary shall not make any payment under this section to such health savings account.

"(g) ADVANCE PAYMENT.—To the extent that the Secretary determines feasible, payment under this section may be made in advance on a monthly basis under rules similar to the rules of section 7529.".

(2) DISCLOSURE OF RETURN INFORMATION TO CARRYOUT ADVANCE PAYMENTS.—

(A) IN GENERAL.—Section 6103(l) of such Code is amended by adding at the end the following new paragraph:

"(23) DISCLOSURE OF RETURN INFORMATION RELATED TO ADVANCE PAYMENT OF HEALTH INSURANCE COVERAGE CREDIT.—The Secretary may, on behalf of taxpayers eligible for the credit under section 36C, disclose to a provider of eligible health insurance (as defined in section 36C(e)) or a trustee of a health savings account (and persons acting on behalf of such provider or such trustee), return information with respect to any such taxpayer only to the extent necessary (as prescribed by regulations issued by the Secretary) to carry out sections 7529 (relating to advance payment of health insurance coverage credit) and 7530 (relating to excess health insurance coverage credit payable to health savings account).".

(B) CONFIDENTIALITY OF INFORMATION.—Section 6103(a)(3) of such Code is amended by striking "or (21)" and inserting "(21), or (23)".

(C) UNAUTHORIZED DISCLOSURE.—Section 7213(a)(2) of such Code is amended by striking "or (21)" and inserting "(21), or (23)".

(c) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of such Code is amended by adding at the end the following new section:

"SEC. 6050X. RETURNS RELATING TO HEALTH INSURANCE COVERAGE CREDIT.

"(a) REQUIREMENT OF REPORTING.—Every person who provides eligible health insurance for any month of any calendar year with respect to any individual shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to each such individual. With respect to any individual with respect to whom payments under section 7529 are made by the Secretary, the Secretary may require that reporting under subsection (b) be made on a monthly basis.

"(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

"(1) is in such form as the Secretary may prescribe, and

"(2) contains, with respect to each policy of eligible health insurance—

"(A) the name, address, and TIN of each individual covered under such policy,

"(B) the premiums paid with respect to such policy,

"(C) the amount of advance payments made on behalf of the individual under section 7529,

"(D) the months during which such health insurance is provided to the individual, and

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

"(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

"(1) the name and address of the person required to make such return and the phone number of the information contact for such person, and

"(2) the information required to be shown on the return with respect to such individual.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year to which such statement relates.

"(d) DEFINITIONS.—For purposes of this section, terms used in this section which are also used in section

36C shall have the same meaning as when used in section 36C.".

(2) ASSESSABLE PENALTIES.—

(A) Section 6724(d)(1)(B) of such Code is amended by striking "or" at the end of clause (xxiv), by inserting "or" at the end of clause (xxv), and by inserting after clause (xxv) the following new clause:

"(xxvi) section 6050X (relating to returns relating to health insurance coverage credit),".

(B) Section 6724(d)(2) of such Code is amended by striking "or" at the end of subparagraph (HH), by striking the period at the end of subparagraph (II) and inserting ", or", and by adding after subparagraph (II) the following new subparagraph:

"(JJ) section 6050X (relating to returns relating to health insurance coverage credit).".

(d) CONFORMING AMENDMENTS.—

(1) Section 35(g) of such Code is amended by adding at the end the following new paragraph:

"(13) COORDINATION WITH HEALTH INSURANCE COVERAGE CREDIT.—

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

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

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

"(I) the sum of any advance payments made on behalf of the taxpayer under sections 7527 and 7529 for months during such taxable year, over

"(II) the sum of the credits allowed under this section (determined without regard to paragraph (1)) and

section 36C (determined without regard to subsection (h)(5)(A) thereof) for such taxable year, and

"(ii) section 36C(h)(5)(B) shall not apply with respect to such taxpayer for such taxable year.".

(2) Section 162(l) of such Code is amended by adding at the end the following new paragraph:

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

"(A) the amount of the credit allowable to such taxpayer under section 36C (determined without regard to subsection (h)(5)(A) thereof) for such taxable year, plus

"(B) the aggregate payments made with respect to the taxpayer under section 7530 for months during such taxable year.".

(3) Section 1324(b)(2) of title 31, United States Code is amended—

(A) by inserting "36C," after "36B,", and

(B) by striking "or 6431" and inserting "6431, or 7530".

(4) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36B the following new item:

"Sec. 36C. Health insurance coverage.".

(5) The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by adding at the end the following new item:

"Sec. 6050X. Returns relating to health insurance coverage credit.".

(6) The table of sections for chapter 77 of such Code is amended by adding at the end the following new item:

"Sec. 7529. Advance payment of health insurance coverage credit.
"Sec. 7530. Excess health insurance coverage credit payable to health savings account.".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2019.

SEC. 222. INCLUSION OF EXCESS COVERAGE UNDER EMPLOYER-PROVIDED HEALTH COVERAGE.

(a) IN GENERAL.—Section 106 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(h) INCLUSION OF EXCESS COVERAGE UNDER EMPLOYER-PROVIDED HEALTH COVERAGE.—

"(1) IN GENERAL.—Notwithstanding any other provision of this section or section 105(b), if the taxpayer (or, in the case of a joint return, either spouse) is covered under one or more specified employer-provided health coverages at any time during a calendar month, there shall be included in the gross income of the taxpayer for the taxable year which includes such month an amount equal to the monthly excess benefit (if any) with respect to each such coverage.

"(2) MONTHLY EXCESS BENEFIT.—For purposes of this subsection, the term 'monthly excess benefit' means, with respect to any applicable-employer sponsored coverage, the excess (if any) of—

"(A) the cost of the specified employer-provided health coverage for the calendar month, over

"(B) an amount equal to 1/12 of the annual limitation with respect to such coverage for the calendar year in which the month occurs.

"(3) SPECIFIED EMPLOYER-PROVIDED HEALTH COVERAGE.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'specified employer-provided health coverage' means cov-

erage under any group health plan (within the meaning of section 5000(b)(1)).

"(B) EXCEPTIONS.—The term 'specified employer-provided health coverage' shall not include—

"(i) contributions described in subsection (b) or (d),

"(ii) any coverage (whether through insurance or otherwise) described in section 9832(c)(1) (other than subparagraph (G) thereof) or for long-term care,

"(iii) any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye, and

"(iv) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income (determined without regard to this subsection) and for which a deduction under section 162(l) is not allowable (determined without regard to paragraph (2)(A) thereof),

"(v) any coverage provided on the basis of employment as a law enforcement officer (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), an employee in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), or an employee providing out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders).

"(C) COVERAGE INCLUDES EMPLOYEE PAID PORTION.—Coverage shall be treated as specified employer-provided health coverage without regard to whether the employer or employee pays for the coverage.

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"(D) AGGREGATION.—All coverage provided on the basis of employment with the same employer shall be treated as one specified employer-provided health coverage for purposes of this subsection. In the case of a joint return, the preceding sentence shall be applied separately with respect to each spouse.]

"(4) DETERMINATION OF COST OF COVERAGE.—For purposes of this subsection—

"(A) IN GENERAL.—The cost of specified employer-provided health coverage shall be determined under rules similar to the rules of section 4980B(f)(4), except that the amount of such cost shall be calculated separately for self-only coverage and other coverage. [In the case of specified employer-provided health coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.]

[(B) HEALTH FSAS.—In the case of specified employer-provided health coverage consisting of coverage under a flexible spending arrangement (as defined in subsection (c)(2)), the cost of the coverage shall be equal to the sum of—]

[(i) the amount of employer contributions under any salary reduction election under the arrangement, plus]

[(ii) the amount determined under subparagraph (A) with respect to any re-

imbursement under the arrangement in excess of the contributions described in clause (i).]

[“(C) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—In the case of specified employer-provided health coverage consisting of coverage under any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2)), the cost of coverage shall be equal to the amount described in section 6051(a)(15).]

“(D) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on other than a monthly basis, the cost shall be allocated to months on such basis as the Secretary may prescribe.

“(5) ANNUAL LIMITATION.—For purposes of this subsection—

“(A) IN GENERAL.—The term ‘annual limitation’ means—

“(i) in the case of self-only coverage, the amount determined by the Secretary to be equal to the 90th percentile of annual premiums for self-only coverage under

group health plans for calendar year 2019, and

"(ii) in the case of coverage other than self-only coverage, the amount determined by the Secretary to be equal to the 90th percentile of annual premiums for coverage other than self-only coverage under group health plans for calendar year 2019.

"(B) ADJUSTMENT FOR YEARS AFTER 2020.—In the case of any calendar year after 2020, the amount under clause (i)(I) and the amount under clause (i)(II) shall each be increased by an amount equal to—

"(i) such amount, multiplied by—

"(ii) the cost-of-living adjustment determined under section 1(f)(3) for such calendar year, determined

"(I) by substituting 'calendar year 2019' for 'calendar year 1992', and

"(II) by substituting for the CPI referred to in section 1(f)(3)(A) the amount that such CPI would have been if the annual percentage increase

in CPI with respect to each year after 2019 had been two percentage points greater.

"(C) TERMS RELATED TO CPI.—

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

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

"(D) ROUNDING.—Any increase determined under subparagraph (B) shall be rounded to the nearest multiple of $50.

"(6) INCLUSION NOT TO EXCEED EXCLUDABLE COVERAGE.—The amount included in the taxpayer's gross income under paragraph (1) with respect to any specified employer-provided health coverage for any month shall not exceed the amount which (but for this subsection) would be excludible from the taxpayer's gross income under this section or section

105(b) with respect to such coverage for such month.".

(b) HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—Section 162(l)(2) of such Code is amended—

(1) by redesignating subparagraphs (A), (B), and (C) as subparagraphs (B), (C), and (D), respectively,

(2) by striking "DOLLAR AMOUNT" in the heading of subparagraph (B) (as so redesignated) and inserting "EARNED INCOME FROM TRADE OR BUSINESS", and

(3) by inserting before subparagraph (B) (as so redesignated) the following new subparagraph:

"(A) IN GENERAL.—The amount allowed as a deduction under paragraph (1) with respect to any taxpayer for any calendar month shall not exceed 1/12 of the annual limitation (as defined in section 106(h)(5)) with respect to such coverage for the calendar year in which such month begins.".

(c) REPORTING REQUIREMENT.—Section 6051(a) of such Code is amended by striking "and" at the end of paragraph (14), by striking the period at the end of para-

graph (15) and inserting "and", and by inserting after paragraph (15) the following new paragraph:

"(16) the total amount of specified employer-provided health coverages which is includible in gross income by reason of section 106(h).".

(d) APPLICATION TO WAGE WITHHOLDING.—Section 3401(a) of such Code is amended—

(1) by striking paragraph (21),

(2) by redesignating paragraphs (22) and (23) as paragraphs (21) and (22), respectively, and

(3) by striking "section 106(d)" in paragraph (21) (as so redesignated) and inserting "section 106".

[(e) RETIRED PUBLIC SAFETY OFFICERS.—Section 402(l)(4)(D) of such Code is amended by adding at the end the following: "Such term shall not include any premium for coverage by an accident or health insurance plan for any month to the extent such premium exceeds 1/12 of the annual limitation (as defined in section 106(h)(5) with respect to such coverage for the calendar year in which such month begins.".]

[(f) EARNED INCOME CREDIT UNAFFECTED BY LIMITATIONS.—Section 32(c)(2)(B) of such Code is amended by redesignating clauses (v) and (vi) as clauses (vi) and

(vii), respectively, and by inserting after clause (iv) the following new clause:]

[''(v) the earned income of an individual shall be computed without regard to section 106(h),''.]

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2019.

SEC. 223. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAVINGS ACCOUNT INCREASED TO AMOUNT OF DEDUCTIBLE AND OUT-OF-POCKET LIMITATION.

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

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

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

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

(2) by striking ''determined by'' in subparagraph (B) thereof and all that follows through '' 'cal-

endar year 2003'." and inserting "determined by substituting 'calendar year 2003' for 'calendar year 1992' in subparagraph (B) thereof .".

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

[SEC. 224. CLARIFYING APPLICATION OF PROHIBITION ON FEDERAL FUNDING OF ABORTIONS WITH RESPECT TO CERTAIN BENEFITS AND PROGRAMS.

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

[(1) by striking "Any term" and inserting the following:]

["(1) IN GENERAL.—Any term"; and]

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

["(2) EXCLUSION OF HEALTH PLANS INCLUDING COVERAGE FOR ABORTION.—]

["(A) IN GENERAL.—The term 'qualified health plan' does not include any health plan that includes coverage for abortions (other than

any abortion or treatment described in section 307 or 308 of title 1, United States Code).]

[“(B) SEPARATE ABORTION COVERAGE OR PLAN ALLOWED.—]

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

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

[(b) REPEAL OF SUPERCEDED RULES FOR ABORTION COVERAGE BY EXCHANGE PLANS.—Section 1303(b) of Public Law 111–148 (42 U.S.C. 18023(b)) is amended by striking paragraphs (2) and (3) and by redesignating paragraph (4) as paragraph (2).]

[(c) EFFECTIVE DATE.—]

[(1) SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT.—The amendments made by subsection (a) shall apply to taxable years beginning after December 31, 2017.]

[(2) OTHER PROVISIONS.—The amendments made by subsection (b) shall apply to plan years beginning after December 31, 2017.]

SEC. 225. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CONTRIBUTIONS TO THE SAME HEALTH SAVINGS ACCOUNT.

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

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

"(A) IN GENERAL.—In the case of individuals who are married to each other, if both spouses are eligible individuals and either spouse has family coverage under a high de-

ductible health plan as of the first day of any month—

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

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

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

"(B) TREATMENT OF ADDITIONAL CONTRIBUTION AMOUNTS.—If both spouses referred to in subparagraph (A) have attained age 55 before the close of the taxable year, the limitation referred to in subparagraph (A)(iii) which is subject to division between the spouses shall include the additional contribution amounts de-

termined under paragraph (3) for both spouses. In any other case, any additional contribution amount determined under paragraph (3) shall not be taken into account under subparagraph (A)(iii) and shall not be subject to division between the spouses.".

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

SEC. 226. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT.

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

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

as having been established on the date that such coverage begins.''.

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