

115TH CONGRESS }
1st Session

HOUSE OF REPRESENTATIVES

{ REPORT
115-000

**AMERICAN HEALTH CARE
ACT OF 2017**

R E P O R T

OF THE

**COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES**

TO ACCOMPANY

H.R. 0000

together with
MINORITY VIEWS



MARCH 00, 2017.—Committed to the Committee of the Whole House on
the State of the Union and ordered to be printed

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U.S. GOVERNMENT PUBLISHING OFFICE

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WASHINGTON : 2017

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AMERICAN HEALTH CARE ACT OF 2017

MARCH 00, 2017.—Committed to the Committee of the Whole House on the State
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Mrs. BLACK, from the Committee on the Budget,
submitted the following

R E P O R T

together with

MINORITY VIEWS

[To accompany H.R. 0000]

[Including cost estimate of the Congressional Budget Office]

The Committee on the Budget, to whom reconciliation recommendations were submitted pursuant to title II of S. Con. Res. 3, the concurrent resolution on the budget for fiscal year 2017, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

INTRODUCTION BY THE COMMITTEE ON THE BUDGET

What is often called President Obama’s “signature” achievement is now well known to be a defining failure. The Affordable Care Act [ACA]¹ has led to higher insurance premiums and deductibles; has limited consumers’ choices of doctors and health plans; has deprived millions of the coverage they had; and has imposed taxes aimed at compelling people to purchase health coverage they do not want. Insurance markets are collapsing, and total national health care spending is projected to more than double during the next three decades. All these outcomes and more are precisely contrary to what the law’s authors promised.

For these and numerous other reasons, the ACA, or Obamacare, must be repealed. Yet a return to the *status quo ante* is not acceptable either. Repealing Obamacare merely begins the process of establishing truly patient-centered health care in America—and aspects of both are contained in this legislation, the “American Health Care Act”. This measure is just one component of a broader effort to transform the Nation’s troubled health care network. It will be supplemented by other elements, described below.

The Essential Folly of Obamacare

To fully appreciate the character of this transformation, it is critical to look deeper than Obamacare’s many evident failures and understand *why* it failed. Without this recognition, there can be no real change; policymakers will simply fall back into the seductive but false beliefs that spawned Obamacare in the first place.

Health care comprises a vast network of doctors and nurses, technicians, medical device manufacturers, pharmaceutical makers, hospitals and in-home services, educational institutions, financial arrangements, and, above all, patients—along with numerous others. It is a complex, sophisticated, and dynamic set of interactions that consumes more than \$3 trillion of the Nation’s resources and represents about one-fifth of the economy.² It is a sector in which the participants themselves—not experts, academics, or bureaucrats—are clearly best suited to establishing effective and efficient means of delivering this uniquely valued service.

Nevertheless, for decades, Federal policymakers have relentlessly sought to *systematize* health care and impose a government-con-

¹The legislation commonly called the Affordable Care Act consists of the two related measures enacted in March 2010 that constituted the health care legislation: the “Patient Protection and Affordable Care Act” (Public Law 111–148), and the “Health Care and Education Reconciliation Act of 2010” (Public Law 111–152).

²Centers for Medicare and Medicaid Services, *National Health Expenditures 2015 Highlights*: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>.

trolled model onto the medical sector. The folly of this approach is easy to see. When the Federal Government sets the standards of health care, or determines the required contents of health coverage—and it cannot do one without the other—this practice necessarily limits the options available to consumers, suffocates innovation, and drives up costs. Such an approach must assume that a population of 323 million—living in a wide range of geographical and climatic settings, and possessing diverse cultural backgrounds and values—all require roughly the same set of health care services. States or regions that want something different must queue up for waivers from Washington that may or may not be granted; indeed, 18 States have waivers pending with the Federal Government. Because many people will not voluntarily purchase a product that fails to meet their needs, exceeds their economic resources, or violates their moral principles, the government must coerce them to do so.

The central government approach to health care necessarily leads to a byzantine system of reimbursements that ultimately dictates the kinds of treatments patients receive. Because private insurance companies often follow the politically determined rates, the result is homogenized services even for patients in the private health-care sector. In addition, the government is slow in updating its payment regime to account for the most recent advances in health care technology or delivery, which delays the progress of innovation in patient care. Government price-fixing has become so entrenched that many cannot imagine letting private plans determine payment rates through competition.

Obamacare sprang from the faulty premise that health care delivery and financing could be centrally managed from Washington. The results were entirely predictable, and today are all too clear. They prove that a nationalized approach to health care in America simply cannot work.

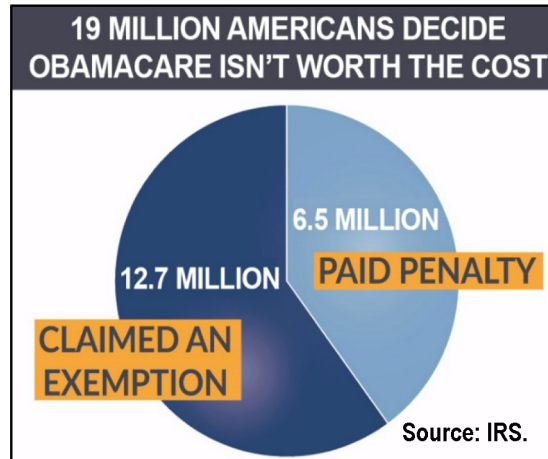
For instance, the ACA established a system of four tiers of insurance coverage—described as bronze, silver, gold, and platinum—that forces insurers to construct their plans according to the demands of Washington, not the marketplace. These tiers mandate the actuarial value of benefits insurers must cover rather than letting insurers design plans for a broader variety of patient needs—thus sharply restricting the available choices.

The resulting limited options are so unsatisfying that enrollments under Obamacare are about half of what was projected when the law was enacted, and millions have chosen to pay its individual “mandate” tax penalty rather than buy coverage they did not want. Approximately 6.5 million taxpayers paid the penalty for the 2015 plan year. Average payments were \$470, and added up to a total of \$3.0 billion. Another 12.7 million individuals applied for an exemption from the tax penalty.³ Thus, 19.2 million individuals have chosen to go without coverage despite the government’s “mandate.” This upends the fatal conceit of Obamacare’s redistributionist financial arrangement: “The young subsidize the old, singles subsidize families, men subsidize women, those who go to the doctor

³ Internal Revenue Service Commissioner John A. Koskinen updated members of Congress regarding 2016 tax filings related to Affordable Care Act provisions, 9 January 2017: <https://www.irs.gov/pub/newsroom/commissionerletteracafileseason.pdf>.

only when sick subsidize those who consume lots of elective or preventive care.”⁴ The cost-shifting scheme has not worked; consequently, Obamacare is facing a financial death spiral.

FIGURE 1



To the extent Obamacare may have expanded health coverage, it has not enhanced access to affordable health care. Due to higher premiums and deductibles, many who have obtained ACA coverage cannot use it because their out-of-pocket medical expenses are too high. Recent reports showed that 50 percent of Obamacare customers were cutting back on care to help manage their health costs. This compares to 33 percent among the general insured population.⁵ In other words, enrollees cannot afford their Affordable Care Act coverage. “[F]or routine illness or injury, having Obamacare is the equivalent of being uninsured * * *.”⁶

The ACA’s many broken promises are not mere accidents or unexpected glitches in an ambitious new government program. They are the inevitable and predictable results of Obamacare’s attempt to extend the reach of the central government ever deeper into Americans’ health care. It has failed because it was destined to fail.

Toward Patient-Centered Health Care

The Republican pledge to “repeal and replace” the ACA has served as a shorthand to describe something deeper—a fundamental *transformation* of health care policy toward a better strategy for true reform. The phrase reflects a more essential and profound change in how Americans should *think about* health care. It grows from a different concept more deeply rooted in the American tradition of freedom and personal choice, coupled with the cost-saving innovations that creative markets produce. As Senator Alexander of Tennessee has said: “[W]e will build better systems pro-

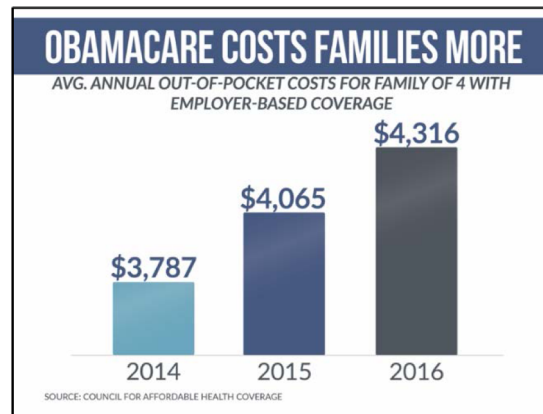
⁴Holman W. Jenkins Jr., “Obamacare 2.0,” *The Wall Street Journal*, 8 March 2017.

⁵GfK, “To Reduce Health Costs, 50% of ACA Exchange Customers Are Cutting Back on Care—GfK Study,” 27 October 2016: <http://www.gfk.com/en-us/insights/press-release/to-reduce-health-costs-50-of-aca-exchange-customers-are-cutting-back-on-care-gfk-study/>.

⁶Jenkins, op. cit.

viding Americans with more choices of insurance that costs less. Note I say systems, not one system * * *. We don't want to replace a failed Obamacare Federal system with another failed Federal system. So, we will build better systems providing Americans with more choices of insurance that costs less. We will do this by moving more health care decisions out of Washington and into the hands of States and patients * * *.”⁷

FIGURE 2



To put this another way: “In a nation of over 323 million people, each with different needs and circumstances, it makes no sense for one federal agency to dictate the contents of every American’s health insurance plan.”⁸

Four principles guide the formulation of Republicans’ approach to health care:

- Lower costs;
- Provide more choices;
- Put patients in control;
- Ensure universal access to health care.

Provisions developed by the authorizing committees (detailed further in the committee submissions) follow this guidance. They repeal some of the most paternalistic components of Obamacare, such as the individual and employer “mandate” tax penalties. They expand access and affordability by providing for portable, monthly tax credits not tied to a job or a Washington-mandated program. The credit is based on age and family size, so it evolves with the health care needs of the individual over time, and phases out as income rises. Further, the credit will be available for individuals with no other form of insurance to take with them from job to job, to take home, to start a business, or to raise a family. Lower costs, resulting from increased competition and choice, will provide greater access to care for everyday Americans.

⁷ Senator A. Lamar Alexander Jr., floor speech in the United States Senate, 10 January 2017.

⁸ The Speaker’s Health Care Reform Task Force, *A Better Way: Our Vision for a Confident America—Health Care*, 22 June 2016, p. 12.

The reforms will make more options available for individuals and families, who will be free to choose the health plan that best meets their needs. Protections and access to care for individuals with pre-existing conditions will continue. Further, by increasing the amount of money that can be placed in health savings accounts, coupled with other reforms, the policies will allow individuals and families to save and spend their health care dollars the way they want.

These provisions will be implemented in a way that ensures a stable transition, one that does not disrupt people's current coverage, or the insurance market.

A key component of this strategy involves the restoration of federalism in health care—giving States more flexibility to handle health care arrangements for their distinctive populations. There is ample evidence that States are capable of doing so. A prime example is Massachusetts, a leader in health care market reform for more than a decade. Yet even Massachusetts, not a conservative State, seeks greater autonomy in determining factors such as a State-specific actuarial value calculator and a State-specific risk adjustment system.⁹ The State also prefers greater administrative control over rules and regulations to address compliance more directly than the Federal Government can. “States have been in the business of regulating health insurance for decades. They should be empowered to make the right tradeoffs between consumer protections and individual choice, not regulators in Washington.”¹⁰

Some touted the Massachusetts approach as a model for national health care reform. It is not. It is a good model *for Massachusetts*. Other States have different kinds of populations and, hence, different approaches to health care; what works for a family farmer in Iowa might not work for a metropolitan New Yorker employed by a large financial firm—or vice versa.

The Healthy Indiana Plan provided the State's residents who did not qualify for Medicaid with access to health benefits such as physician services, prescription drugs, inpatient and outpatient hospital care, and disease management, all without additional funding. In Utah, health insurers are exchanging data and analytics between coverage and care providers. This approach enables doctors and hospitals to improve the quality of care while simultaneously tracking its costs. Physician groups participating in the program reduced hospital readmission rates by 28 percent relative to the rates of non-participating doctors. Completion of key cancer screenings for women improved by more than 10 percent, and participating providers reported average member satisfaction scores of 87 percent.¹¹

In another example of State initiatives, before the ACA, 34 States had high-risk pools for their vulnerable populations. Among the most successful was Minnesota's, which enrolled about 30,000 State residents. The program mainly provided comprehensive

⁹“Read the letter Governor Baker sent to Congress,” *The Boston Globe*, 12 January 2017: <https://www.bostonglobe.com/metro/2017/01/12/read-letter-governor-baker-sent-congress/h9m7B1HrkewyRjxNiNgJnK/story.html>.

¹⁰*A Better Way* op. cit., p. 12.

¹¹Utah Business, “Regence, Utah Physician Groups Report Positive Results from New Care Management Model,” Press Release, 20 February 2017: <https://www.utahbusiness.com/regence-utah-physicians-group-report-positive-results-for-care-management-model/>.

major medical coverage for people with pre-existing conditions.¹² In neighboring Wisconsin, officials had to modify their high-risk pool several times, but by 2012 the plan covered a record 21,770 enrollees and offered a variety of coverage options from low-deductible, high-premium to high-deductible, low-premium.¹³ Utah and Washington State also had their own high-risk pools. All these were supplanted by the costly, Washington-centered control of Obamacare. Under the “American Health Care Act”, States will have the opportunity to assist high-risk individuals or fund innovation programs to care for their unique patient populations.

Greater State flexibility also will come through modernizing Medicaid for the 21st Century. Significant reforms will ensure the program is available for the populations it was intended to serve: children, pregnant women, the aged, and the disabled. A reformed payment structure will give States greater flexibility and control to meet their varied needs.

A recent account in *The Wall Street Journal* illustrated how some of the Nation’s governors, not waiting for Washington, already have begun seeking cost-saving reforms to their respective Medicaid programs. “Maine, for example, may limit most people on Medicaid to five years of benefits. Kentucky could require many recipients to work. Wisconsin wants to drug-test enrollees.”¹⁴ These modifications do not, however, “provide a window into how an overhaul of Medicaid at the national level by Congress could reshape the program for low-income Americans across the country,” as the article suggests.¹⁵ To the contrary, they demonstrate how greater State flexibility can lead to faster and better-tailored reform of Medicaid—and of health care generally. Under current law, these States had to appeal to a domineering Federal bureaucracy to receive permission, in the form of Medicaid waivers, to pursue these reforms. The process is lengthy, slowing reform, and sometimes the waivers are never granted. The Federal Government has denied State requests to waive certain Medicaid benefits; has denied most attempts to impose cost-sharing in amounts greater than those allowed under Federal law; and never approved Pennsylvania’s attempt to include a work requirement for all able-bodied adults, 21 to 64 years old, as a condition of eligibility.¹⁶

That is fundamentally what the Republican approach to health care aims to overturn. It rejects the tired and discredited notion that Washington knows best, that health care delivery and financing can be centrally planned and systematized.

All of this, however, is just the beginning of what might be possible by breaking out of the government-centered model for health care. Talk of medical innovation often provokes thoughts of new

¹² Courtney Burke and Lynn Blewett, “All High-Risk Pools Are Not Equal: Examining The Minnesota Model,” Health Affairs Blog, 19 March 2010: <http://healthaffairs.org/blog/2010/03/19/all-high-risk-pools-are-not-equal-examining-the-minnesota-model/>.

¹³ Steven Walters, “Walters: Wisconsin insurance plan may enter health-care debate,” *The Janesville Gazette*, 16 January 2017: <http://www.gazetextra.com/20170116/walters-wisconsin-insurance-plan-may-enter-health-care-debate>

¹⁴ “States Push to Revise Medicaid Programs,” *The Wall Street Journal*, 24 February 2017.

¹⁵ *Ibid.*

¹⁶ Centers for Medicare and Medicaid Services, letter from Administrator Marilyn Tavenner to Pennsylvania Department of Public Welfare Secretary Mackereth regarding Healthy Pennsylvania Section 1115 demonstration, 28 April 2014: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/Healthy-Pennsylvania-Private-Coverage-Option-Demonstration/pa-healthy-ca.pdf>.

technologies or pharmaceutical products. Yet innovation can occur in health care delivery as well, and many concepts—such as skilled nursing facilities and outpatient surgery—started small, in the private sector, and eventually became mainstream.

The path toward true health care reform begins with this legislation. The “American Health Care Act” sheds the notion that health care can or should be managed by regulation and mandate, by academics and Washington bureaucrats. It plants the seed for a new vision of health care, one rooted where it should be—in the decisions and choices of patients and their doctors. Patient-centered health care is the true reform for the 21st Century.

Advancing Patient-Centered Care on Three Fronts

The provisions of this legislation are being pursued through the process of budget “reconciliation.” It is a powerful instrument for policy reform, provided for under Section 310 of the Congressional Budget and Impoundment Control Act of 1974 [Budget Act]. A principal advantage of reconciliation is that it cannot be filibustered in the Senate. On the other hand, a reconciliation bill in the Senate is limited to budget-related matters; its provisions must affect spending or revenue. Consequently, many of the onerous mandates and regulations of the Affordable Care Act will have to be addressed through subsequent legislation or administrative action. The current measure represents one of three fronts for advancing patient-centered health care reform.

A second front will be administrative action. The Obamacare legislation contains 1,442 instances in which it grants the Department of Health and Human Services [HHS] broad discretion in determining Federal health care policy. Apart from subjecting individuals’ medical care to the dictates of government bureaucrats, this constitutes a dangerous expansion of the administrative state.

President Trump has already started rolling back regulation with his Executive Order 13765, which includes the following provisions:

- It allows the Secretary of HHS, and the heads of all other executive departments and agencies “to waive, defer, grant exemptions from, or delay the implementation” of provisions or requirements of Obamacare that would fiscally burden any State or impose a cost, fee, tax, penalty, or regulatory burden on individuals, families, health care providers, health insurers, patients, recipients of health care services, purchasers of health insurance, or makers of medical devices, products, or medications.
- It allows the HHS Secretary and other agency heads to provide greater flexibility to States and cooperate with them in implementing health care programs.
- It authorizes agency heads to promote an open market in interstate commerce for offering health care services or health insurance, “with the goal of achieving and preserving maximum options for patients and consumers.”

Another element of this second front will be the HHS Secretary’s exercise of his own authority to modify or rescind previous administrative provisions under the Affordable Care Act. On 15 February

2017, Secretary Price took the first step by issuing new proposed regulations to stabilize individual and small group markets damaged by Obamacare. Specifically, these regulations reduce the number of special enrollment periods; require 100-percent enrollment verification with documentation for special enrollment periods; and shorten the open enrollment period deadline from 31 January to 15 December, encouraging full-year coverage.

The third front will be additional legislative provisions that cannot be included in reconciliation. These might include selling insurance across State lines, or implementing the tort reform provisions of H.R. 1215, the “Protecting Access to Care Act of 2017”. Other options could include allowing small businesses to pool their employees together to purchase association health plans, and eliminating the Independent Payment Advisory Board, a group of unelected bureaucrats authorized under the ACA to recommend cuts in Medicare provider payments if the program’s spending exceeds certain targets.

Setting the Stage for Entitlement Reform

Another benefit of this legislation is that it can start the long-needed effort toward reforming the government’s unsustainable entitlement programs. Federal entitlements, many of them launched or expanded in President Johnson’s Great Society, are failing many of the people they were intended to serve. Income assistance programs often trap their beneficiaries in a lifetime of dependency. Medical programs such as Medicaid subject enrollees to second-rate care—if they can get care at all. Programs such as the ACA actually discourage work and self-sufficiency.

These are the recognizable moral failings of these programs. Equally immoral is how the uncontrolled costs of these programs are loading future generations with debt.

The latest projections show entitlements will constitute the only growth in spending as a share of the economy over the next 10 years and beyond. By 2028, entitlement spending plus net interest is expected to consume all Federal revenue, meaning all other government activities—such as national defense, education, infrastructure, and research, and myriad others—will have to be financed on borrowed money. Ten years later, by 2038, the situation will worsen, as a mere handful of programs—Social Security and health care entitlement spending—plus net interest are expected to consume all Federal revenue; at that point, all discretionary spending *and all other direct spending* will be debt-financed. These trends result not from temporary surges in spending or economic downturns, but from permanent government spending programs. *This is an entrenched, structural excess of spending over revenues.*

This spending is driving the government’s mounting deficits and debt. The most recent long-term estimates from the Congressional Budget Office [CBO] project Federal debt held by the public—which stands at roughly 75 percent of GDP today—will surge to 110 percent of GDP in the next 20 years, and will exceed 141 percent of GDP by 2046.¹⁷ That figure is well beyond the 60-percent ratio

¹⁷ Congressional Budget Office, *The 2016 Long-Term Budget Outlook*, July 2016.

adopted in the European Union's Maastricht Treaty, the maximum level most economists consider sustainable.

CBO notes it is impossible to predict how long the Nation could sustain such growth in Federal debt, but at some point investors would begin to doubt the government's willingness or ability to pay its debt obligations. This would require the government to pay much higher interest costs to borrow money, resulting in significant negative consequences for the economy and the Federal budget. This growing and unsustainable debt would restrict policy-makers' ability to use tax and spending policies to respond to unexpected challenges, such as economic downturns, financial crises, or national security emergencies, and would pose substantial risks to the Nation.

Clearly, entitlement reform is indispensable for taking control of the Federal Government's fiscal condition. It begins with the "American Health Care Act".

Cost Estimate of the Legislation

The three-front strategy for health care reform has significant implications with regard to the cost estimate of this legislation. The analysis by CBO and the Joint Committee on Taxation [JCT], released on 13 March 2017, reflects only the provisions of this measure; it does not account for further planned actions that cannot be included in a reconciliation bill. For instance, it cannot show how deregulatory initiatives by the Executive Branch would allow insurers to develop a greater variety of coverage options, some at lower costs, and compete for a broader range of customers. Nor can it evaluate the effects of interstate purchasing—should such a policy be enacted—which might also enhance competition and lead to more choices of policies. This is because the two agencies can only estimate the legislation at hand.

With those considerations in mind, the CBO/JCT estimate of the "American Health Care Act" offers important projections of the potential effects of the legislation.

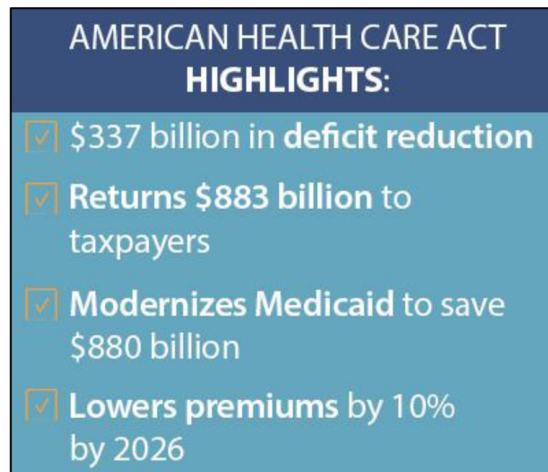
Reduced Spending and Lower Deficits. The bill as reported by the Budget Committee would reduce projected spending by \$1.2 trillion over the period of 2017 through 2026, mainly due to reforms to the Medicaid Program and the elimination of the ACA's insurance subsidies for non-group coverage. The measure also would return \$883 billion to taxpayers by eliminating some of Obamacare's burdensome tax hikes. The net effect is a reduction in projected deficits of \$336.6 billion.¹⁸

Stability of the Insurance Market. Confirming Republican expectations, the analysis projects stability in the nongroup health insurance market. "[K]ey factors bringing about market stability include subsidies to purchase insurance, which would maintain sufficient demand for insurance by people with low health care expenditures, and grants to states from the Patient and State Stability Fund, which would reduce the costs to insurers of people with high health care expenditures." Although the new tax credits would be struc-

¹⁸ Congressional Budget Office Cost Estimate for the "American Health Care Act", 13 March 2017: https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/costestimate/americanhealthcareact_0.pdf.

tured differently from current subsidies, the analysis notes, the other changes would “lower average premiums enough to attract a sufficient number of relatively healthy people to stabilize the market.”¹⁹

FIGURE 3



Lower Insurance Premiums. The estimate projects a near-term (through 2019) bump during transition, but by 2026 average health insurance premiums would be about 10 percent less than under current law. This is partly because premium rates would be determined more by actual risk and market effects rather than by government dictate. The Patient and State Stability Fund would help as well. CBO and JCT also expect a younger mix of enrollees under the legislation.²⁰ In this area, though, the estimate is unable to account for other potential actions that cannot be included here—such as deregulation and other potential changes in law outside the reconciliation process—which would likely contribute to even lower premiums.

Effects on Insurance Coverage. This is where context is especially important. CBO and JCT estimate a significant decline in insurance coverage resulting from the legislation, relative to current law.²¹ The agencies, however, have tended to overestimate the extent to which the individual “mandate” tax encourages a significant boost in insurance purchases. As noted earlier, nearly 20 million people have chosen to remain without coverage by either paying the tax or seeking an exemption from it. Further, CBO counts only “comprehensive major medical policies,” while excluding health savings accounts and plans bought with portable tax credits that give patients choices as opposed to Washington-defined coverage. In addition, the limited breadth of the cost estimate—analyzing in isolation only one of three fronts in the overall health care strategy—limits a full understanding of the health care plan. It cannot

¹⁹ Ibid.

²⁰ Ibid.

²¹ Ibid.

project how many more people would buy coverage if there were a greater variety of affordable options as a result of forthcoming legislative or administrative actions. Hence the full effects on insurance coverage cannot be evaluated until the other components are in place.

No Macroeconomic Feedback Analysis. House rules require a macroeconomic feedback analysis of major legislation to the extent practicable.²² For the “American Health Care Act”, such an evaluation would reflect how the measure’s tax reductions and shrinking deficits might boost economic performance, thereby potentially yielding tax revenues higher than estimated. CBO said, however, that “because of the very short time available to prepare this cost estimate, quantifying and incorporating these macroeconomic effects have not been practicable.”²³

The Budget Committee’s Role in Obamacare Legislation

The major steps in the reconciliation process, as provided for under Section 310 of the Budget Act, and how they apply in this instance, are the following:

The Budget Resolution. Reconciliation can be triggered only by the adoption of a budget resolution. Therefore, the fiscal year 2017 budget resolution, passed in January, carried reconciliation instructions for the Committees on Energy and Commerce and Ways and Means, which have jurisdiction over major health care and tax policies. The directives were written to give the committees maximum flexibility in writing their legislative provisions.

Authorizing Committees. The two authorizing committees marked up legislative provisions pursuant to their instructions and transmitted them to the Committee on the Budget. Detailed descriptions of the provisions are presented in the committees’ submissions.

The Budget Committee. Having received the submissions, the Committee on the Budget, as provided for under Section 310 of the Budget Act, has bound the provisions together, without substantive change, into a single measure—a reconciliation bill—and conducted a markup. The Committee then reported the measure to the House for floor consideration.

Following House passage, the bill will be sent to the Senate, which will consider the measure under that Chamber’s reconciliation process.

²² Clause 8 of Rule XIII of H.Res. 5, the “Rules of the House of Representatives” for the 115th Congress.

²³ Congressional Budget Office Cost Estimate for the “American Health Care Act”, 13 March 2017.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC, March 13, 2017.

Hon. DIANE BLACK,
Chairman, Committee on the Budget,
House of Representatives, Washington, DC.

DEAR CHAIRMAN BLACK: Pursuant to section 2002 of S. Con. Res. 3, the Fiscal Year 2017 Concurrent Resolution on the Budget, as well as section 310 of the Congressional Budget and Impoundment Control Act of 1974, I hereby transmit these recommendations, which have been approved by vote of the Committee on Energy and Commerce, and the appropriate accompanying material including additional, supplemental or dissenting views, to the House Committee on the Budget.

Sincerely,

GREG WALDEN,
Chairman.

COMMITTEE PRINT: BUDGET RECONCILIATION LEGISLATIVE RECOMMENDATIONS RELATING TO REPEAL AND REPLACE OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT; TITLE I—ENERGY AND COMMERCE

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PURPOSE AND SUMMARY

The Patient Protection and Affordable Care Act (PPACA) has failed to live up to the promise of lowering health care costs for individuals and families. The purpose of the Committee on Energy and Commerce's budget reconciliation legislative recommendations is to advance the repeal and replacement of this failed law.

BACKGROUND AND NEED FOR LEGISLATION

The PPACA has led to a deterioration of the health insurance market where most individuals and families have limited choices. Patients have seen premium increases paired with high cost sharing. Nearly one-third of counties have only one insurer offering an exchange plan. The average increase in premiums this year on the healthcare.gov exchange is 25 percent according to data from the Department of Health and Human Services. As a result, 19.2 million taxpayers have chosen to pay the individual mandate penalty or claim an exemption from the mandate.

The PPACA has also dramatically overburdened the Medicaid program. Medicaid is a critical safety net for some of our nation's most vulnerable patients, as the program provides health care for children, pregnant mothers, elderly individuals, blind individuals, and individuals with disabilities. Created in 1965 to finance health care coverage to serve low-income Americans, Medicaid is now the world's largest health insurance program. Medicaid currently covers approximately 72 million Americans—more than Medicare—and up to 98 million may be covered at any one point in a given year.¹

Medicaid is jointly funded by Federal and State governments. According to the Congressional Budget Office, Federal Medicaid outlays are expected to increase dramatically over the coming decade, from \$368 billion in 2016 to \$650 billion in 2027.² According to National Health Expenditure projections, total Medicaid outlays will climb to approximately \$1 trillion each year by the end of a decade.³

Today, Medicaid is one of the fastest growing spending items for States, and accounted for more than 28 percent of State spending in fiscal year 2015, according to the National Association of State Budget Officers.⁴ This portion of State budgets devoted to Medicaid has grown over time, and has accelerated in recent years. Notably, irrespective of whether or not a State chose to expand Medicaid under PPACA, all States are experiencing greater Medicaid program outlays due to the effects of the individual mandate and penalties. A recent estimate by the Congressional Budget Office (CBO) attributed \$281 billion in Federal Medicaid outlays over a decade

¹See the Congressional Budget Office's *Medicaid* baseline, available online here: <https://www.cbo.gov/sites/default/files/recurringdata/51301-2016-03-medicaid.pdf>.

²See the Congressional Budget Office's *Medicaid* baseline, available online here: <https://www.cbo.gov/sites/default/files/recurringdata/51301-2016-03-medicaid.pdf>.

³See the Centers for Medicare & Medicaid Service *National Health Expenditures Data*, available online here: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>.

⁴See the National Association of State Budget Officers, *State Expenditure Report*, available online here: [https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/State%20Expenditure%20Report%20\(Fiscal%202014-2016\)%20-%20S.pdf](https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/State%20Expenditure%20Report%20(Fiscal%202014-2016)%20-%20S.pdf).

to the effect of the individual mandate tax penalty in PPACA, because the mandate has effectively forced many individuals who were previously eligible (but not previously enrolled) to enroll in Medicaid.⁵

As these numbers suggest, the Medicaid safety net is under strain and unfortunately is not serving patients as well as it should. Many State Medicaid programs suffer from significant waste, fraud, and abuse, due to failures in State and Federal oversight. In fact, the Government Accountability Office (GAO) has designated Medicaid as a high-risk program since 2003 due to their concerns about conducting proper oversight of the program.⁶ Medicaid's incentives often lead States to offer more benefits but cut payments to health care providers, which means low-income patients have less and less access to quality care. The result is nationally, only a portion of primary health care providers accept Medicaid beneficiaries—often with even fewer specialists accepting such patients.⁷ On its current path, the Medicaid program is on unsustainable financial footing. This is not merely a fiscal issue, but an issue that jeopardizes the ability of the Federal and State government to take care of the most vulnerable who actually rely on the program.

Unfortunately, PPACA has made this dynamic of not being able to care for the most vulnerable worse. Under PPACA, States may expand Medicaid eligibility to people under the age of 65 with income up to 138 percent of the Federal poverty level (FPL). The law provided enhanced Federal funding for coverage of this new expansion population, in the form of a higher Federal Medical Assistance Percentage (FMAP). Specifically, the Federal government covered 100 percent of the costs for the expansion population through 2016—a 100 percent FMAP. In 2017, the FMAP for this population is 95 percent, and the FMAP gradually diminishes to 90 percent by 2020. Thus, under PPACA, the Federal government covers a higher percentage of the cost of care for able-bodied adults above poverty compared to the disabled, elderly, or children below poverty. In some cases, this may create an incentive for States that face budgetary pressures to use policy tools to reduce benefits, services, or eligibility for the traditional, vulnerable Medicaid populations served by their programs. According to the most recent estimate from the Congressional Budget Office, the provisions of PPACA will cost Federal taxpayers nearly \$1 trillion over the next decade.

For Medicaid to be strengthened and sustained as a vital safety net to provide needed care for our nation's most vulnerable patients for coming decades, Congress and the Centers for Medicare and Medicaid Services (CMS) will be forced to make changes to the program. As GAO has noted, "the effects of unprecedented changes recently made to the Medicaid program will continue to emerge in the coming years and are likely to exacerbate the challenges and

⁵ See the Congressional Budget Office's Budget Option, *Repeal the Individual Health Insurance Mandate*, available online here: <https://www.cbo.gov/budget-options/2016/52232>.

⁶ See the Government Accountability Office's, 2017 High Risk Report, available online here: <http://www.gao.gov/assets/690/682765.pdf>.

⁷ See Avik Roy's Testimony before the Energy & Commerce Health Subcommittee, available online here: <http://docs.house.gov/meetings/IF/IF14/20170201/105498/HHRG-115-IF14-Wstate-RoyA-20170201.pdf> pages 4 and 5.

shortcomings that already exist in federal oversight and management of the program.”⁸

COMMITTEE ACTION

The Committee on Energy and Commerce has convened 31 oversight hearings on the Affordable Care Act through the Subcommittees on Health, the Subcommittee on Oversight and Investigations, and the Full Committee. One-hundred and seven witnesses testified before the Committee, included 38 Administration officials. These hearings focused on a variety of provisions within the law and their implementation. Topics discussed at these hearings include the Cost-Sharing reduction program, the Basic Health Program, the mismanagement of healthcare.gov and information technology systems by HHS and its component agencies, state-based exchanges, the Consumer Operated and Oriented Plan, premium increases resulting from provisions of the law, and the ACA Medicaid expansion.

On March 8, 2017, the full Committee on Energy and Commerce met in open markup session and ordered the Committee Print, as amended, favorably reported to the House by a record vote of 31 yeas and 23 nays.

COMMITTEE VOTES

Clause 3(b) of rule XIII requires the Committee to list the record votes on the motion to report legislation and amendments thereto. The following reflects the record votes taken during the Committee consideration:

⁸ See the Government Accountability Office's, 2017 High Risk Report, available online here: <http://www.gao.gov/assets/690/682765.pdf>.

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 13**

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute offered by Mr. Pallone, No. 1a, to provide a short title.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 23 yeas and 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise		X		Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/08/2017

— COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 14

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute, offered by Ms. Castor, No. 1c, to provide none of the provisions the title (including amendments made by such provisions) shall take effect until such date that the Congressional Budget Office and the Joint Committee on Taxation certify that such provisions (and their amendments) result in lower cost health care (as measured by average premium for comparable benefits), more affordable health care (as measured by the amount paid out of pocket toward health insurance), and better health insurance (as measured by improved health insurance benefits), and no increase in the rate of individuals without health insurance.

DISPOSITION: NOT AGREED TO, by a roll call vote of 23 yeas and 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise		X		Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loebsack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/09/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 15**

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute, offered by Ms. DeGette, No. 1e, to strike section 103.

DISPOSITION: NOT AGREED TO, by a roll call vote of 23 yeas and 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise		X		Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/09/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 16**

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute, offered by Ms. Eshoo, No. 1f, to insert a new section to preserve certain PPACA protections.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 22 yeas and 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise		X		Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters			
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/09/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 17**

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute, offered by Mr. Pallone, No. 1g, to strike section 121.

DISPOSITION: NOT AGREED TO, by a roll call vote of 23 yeas and 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise		X		Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/09/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 18**

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the Amendment in the Nature of a Substitute, offered by Ms. Castor, No. 1h, to strike section 135.

DISPOSITION: NOT AGREED TO, by a roll call vote of 21 yeas and 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel			
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise		X		Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters			
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/09/2017

COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 19

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute, offered by Mr. Green, No. 1j, to strike section 131.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 22 yeas and 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel			
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise		X		Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/09/2017

COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 20

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute, offered by Mr. Lujan, No. 1k, to insert a sense of the House regarding Medicaid.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 22 yeas and 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel			
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise		X		Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/09/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 21**

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute, offered by Mr. Welch, No. 11, to strike section 112(c).

DISPOSITION: NOT AGREED TO, by a roll call vote of 23 yeas and 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise		X		Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/09/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 22**

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute, offered by Mr. Butterfield, No. 1m, to strike section 133.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 23 yeas and 28 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise				Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley				Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello							
Mr. Carter		X					

03/09/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 23**

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute, offered by Ms. Dingell, No. 1n, to provide that the provisions of section 121 shall not take effect if they negatively impact seniors' access to specified Medicaid and PPACA services and supports; to reauthorize section 10202(f)(2) of PPACA and section 6071(h) of the Deficit Reduction Act of 2005; and to direct HHS to report to Congress on developing a long term services and supports financing system.

DISPOSITION: NOT AGREED TO, by a roll call vote of 22 yeas and 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise		X		Ms. Schakowsky			
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/09/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 24**

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute, offered by Mr. Lujan, No. 1o, to insert a section regarding veterans' access to care.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 23 yeas and 29 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise				Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers				Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/09/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 25**

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute, offered by Mr. Green, No. 1p, to strike section 112 and to insert a new section regarding increased FMAP for medical assistance to newly eligible individuals.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 23 yeas and 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise		X		Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNeerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/09/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 26**

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute, offered by Mr. Welch, No. 1q, to insert a new section regarding spending on prescription drugs.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 21 yeas and 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise		X		Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas			
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters			
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson							
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/09/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 27**

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute, offered by Ms. Clarke, No. 1r, to strike section 101.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 23 yeas and 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton				Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise		X		Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/09/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 28**

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute, offered by Ms. DeGette, No. 1s, to insert a new section to provide that no provision of this title shall take effect if such if it would result in a change to the actuarial value of qualified health plans that may be offered through an Exchange established under title 1 of PPACA.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 21 yeas and 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton				Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise		X		Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch			
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz			
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/09/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 29**

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment to the amendment in the nature of a substitute, offered by Mr. Engel, No. 1t, to insert a new section at the end of subtitle B to provide that the provisions of this subtitle, subtitle C, and section 103 (including amendments made by such provisions) shall not take effect until such date that the Centers for Medicare and Medicaid Services conduct an independent assessment on how such provisions will affect hospitals which demonstrate that such provisions will not result in hospital closures or bankruptcy.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 23 yeas and 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush			
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy		X		Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle	X		
Mr. Scalise		X		Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loebsack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long		X		Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

03/09/2017

COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 30

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: An amendment in the nature of a substitute, as amended, offered by Mr. Walden, No. 1.

DISPOSITION: **AGREED TO**, by a roll call vote of 31 yeas and 23 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden	X			Mr. Pallone		X	
Mr. Barton	X			Mr. Rush			
Mr. Upton	X			Ms. Eshoo		X	
Mr. Shimkus	X			Mr. Engel		X	
Mr. Murphy	X			Mr. Green		X	
Mr. Burgess	X			Ms. DeGette		X	
Mrs. Blackburn	X			Mr. Doyle		X	
Mr. Scalise	X			Ms. Schakowsky		X	
Mr. Latta	X			Mr. Butterfield		X	
Mrs. McMorris Rodgers	X			Ms. Matsui		X	
Mr. Harper	X			Ms. Castor		X	
Mr. Lance	X			Mr. Sarbanes		X	
Mr. Guthrie	X			Mr. McNerney		X	
Mr. Olson	X			Mr. Welch		X	
Mr. McKinley	X			Mr. Lujan		X	
Mr. Kinzinger	X			Mr. Tonko		X	
Mr. Griffith	X			Ms. Clarke		X	
Mr. Bilirakis	X			Mr. Loeb sack		X	
Mr. Johnson	X			Mr. Schrader		X	
Mr. Long	X			Mr. Kennedy		X	
Mr. Bucshon	X			Mr. Cardenas		X	
Mr. Flores	X			Mr. Ruiz		X	
Mrs. Brooks	X			Mr. Peters		X	
Mr. Mullin	X			Ms. Dingell		X	
Mr. Hudson	X						
Mr. Collins	X						
Mr. Cramer	X						
Mr. Walberg	X						
Mrs. Walters	X						
Mr. Costello	X						
Mr. Carter	X						

03/09/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 31**

BILL: Committee Print, Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce

AMENDMENT: A motion by Mr. Walden that the Committee do now approve and transmit the recommendations of this Committee and all appropriate accompanying material, including additional, supplemental or dissenting views, to the House Committee on the Budget, as amended. (Final Passage)

DISPOSITION: **AGREED TO**, by a roll call vote of 31 yeas and 23 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden	X			Mr. Pallone		X	
Mr. Barton	X			Mr. Rush			
Mr. Upton	X			Ms. Eshoo		X	
Mr. Shimkus	X			Mr. Engel		X	
Mr. Murphy	X			Mr. Green		X	
Mr. Burgess	X			Ms. DeGette		X	
Mrs. Blackburn	X			Mr. Doyle		X	
Mr. Scalise	X			Ms. Schakowsky		X	
Mr. Latta	X			Mr. Butterfield		X	
rs. McMorris Rodgers	X			Ms. Matsui		X	
Mr. Harper	X			Ms. Castor		X	
Mr. Lance	X			Mr. Sarbanes		X	
Mr. Guthrie	X			Mr. McNerney		X	
Mr. Olson	X			Mr. Welch		X	
Mr. McKinley	X			Mr. Lujan		X	
Mr. Kinzinger	X			Mr. Tonko		X	
Mr. Griffith	X			Ms. Clarke		X	
Mr. Bilirakis	X			Mr. Loeb sack		X	
Mr. Johnson	X			Mr. Schrader		X	
Mr. Long	X			Mr. Kennedy		X	
Mr. Bucshon	X			Mr. Cardenas		X	
Mr. Flores	X			Mr. Ruiz		X	
Mrs. Brooks	X			Mr. Peters		X	
Mr. Mullin	X			Ms. Dingell		X	
Mr. Hudson	X						
Mr. Collins	X						
Mr. Cramer	X						
Mr. Walberg	X						
Mrs. Walters	X						
Mr. Costello	X						
Mr. Carter	X						

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OVERSIGHT FINDINGS AND RECOMMENDATIONS

Pursuant to clause 2(b)(1) of rule X and clause 3(c)(1) of rule XIII, has not held hearings on the Committee Print: Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; Title I—Energy and Commerce.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

Pursuant to clause 3(c)(2) of rule XIII, the Committee finds that the Committee Print would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

March 13, 2017.

American Health Care Act

*Budget Reconciliation Recommendations of the House Committees
on Ways and Means and Energy and Commerce, March 9, 2017*

SUMMARY

The Concurrent Resolution on the Budget for Fiscal Year 2017 directed the House Committees on Ways and Means and Energy and Commerce to develop legislation to reduce the deficit. The Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have produced an estimate of the budgetary effects of the American Health Care Act, which combines the pieces of legislation approved by the two committees pursuant to that resolution. In consultation with the budget committees, CBO used its March 2016 baseline with adjustments for subsequently enacted legislation, which underlies the resolution, as the benchmark to measure the cost of the legislation.

Effects on the Federal Budget

CBO and JCT estimate that enacting the legislation would reduce federal deficits by \$337 billion over the 2017–2026 period. That total consists of \$323 billion in on-budget savings and \$13 billion in off-budget savings. Outlays would be reduced by \$1.2 trillion over the period, and revenues would be reduced by \$0.9 trillion.

The largest savings would come from reductions in outlays for Medicaid and from the elimination of the Affordable Care Act's (ACA's) subsidies for nongroup health insurance. The largest costs would come from repealing many of the changes the ACA made to the Internal Revenue Code—including an increase in the Hospital Insurance payroll tax rate for high-income taxpayers, a surtax on those taxpayers' net investment income, and annual fees imposed on health insurers—and from the establishment of a new tax credit for health insurance.

Pay-as-you-go procedures apply because enacting the legislation would affect direct spending and revenues. CBO and JCT estimate that enacting the legislation would not increase net direct spending or on-budget deficits by more than \$5 billion in any of the four consecutive 10-year periods beginning in 2027.

Effects on Health Insurance Coverage

To estimate the budgetary effects, CBO and JCT projected how the legislation would change the number of people who obtain federally subsidized health insurance through Medicaid, the nongroup market, and the employment-based market, as well as many other factors.

CBO and JCT estimate that, in 2018, 14 million more people would be uninsured under the legislation than under current law. Most of that increase would stem from repealing the penalties associated with the individual mandate. Some of those people would choose not to have insurance because they chose to be covered by insurance under current law only to avoid paying the penalties, and some people would forgo insurance in response to higher premiums.

Later, following additional changes to subsidies for insurance purchased in the nongroup market and to the Medicaid program, the increase in the number of uninsured people relative to the number under current law would rise to 21 million in 2020 and then to 24 million in 2026. The reductions in insurance coverage between 2018 and 2026 would stem in large part from changes in Medicaid enrollment—because some states would discontinue their expansion of eligibility, some states that would have expanded eligibility in the future would choose not to do so, and per-enrollee spending in the program would be capped. In 2026, an estimated 52 million people would be uninsured, compared with 28 million who would lack insurance that year under current law.

Stability of the Health Insurance Market

Decisions about offering and purchasing health insurance depend on the stability of the health insurance market—that is, on having insurers participating in most areas of the country and on the likelihood of premiums’ not rising in an unsustainable spiral. The market for insurance purchased individually (that is, nongroup coverage) would be unstable, for example, if the people who wanted to buy coverage at any offered price would have average health care expenditures so high that offering the insurance would be unprofitable. In CBO and JCT’s assessment, however, the nongroup market would probably be stable in most areas under either current law or the legislation.

Under current law, most subsidized enrollees purchasing health insurance coverage in the nongroup market are largely insulated from increases in premiums because their out-of-pocket payments for premiums are based on a percentage of their income; the government pays the difference. The subsidies to purchase coverage combined with the penalties paid by uninsured people stemming from the individual mandate are anticipated to cause sufficient demand for insurance by people with low health care expenditures for the market to be stable.

Under the legislation, in the agencies’ view, key factors bringing about market stability include subsidies to purchase insurance, which would maintain sufficient demand for insurance by people with low health care expenditures, and grants to states from the Patient and State Stability Fund, which would reduce the costs to

insurers of people with high health care expenditures. Even though the new tax credits would be structured differently from the current subsidies and would generally be less generous for those receiving subsidies under current law, the other changes would, in the agencies' view, lower average premiums enough to attract a sufficient number of relatively healthy people to stabilize the market.

Effects on Premiums

The legislation would tend to increase average premiums in the nongroup market prior to 2020 and lower average premiums thereafter, relative to projections under current law. In 2018 and 2019, according to CBO and JCT's estimates, average premiums for single policyholders in the nongroup market would be 15 percent to 20 percent higher than under current law, mainly because the individual mandate penalties would be eliminated, inducing fewer comparatively healthy people to sign up.

Starting in 2020, the increase in average premiums from repealing the individual mandate penalties would be more than offset by the combination of several factors that would decrease those premiums: grants to states from the Patient and State Stability Fund (which CBO and JCT expect to largely be used by states to limit the costs to insurers of enrollees with very high claims); the elimination of the requirement for insurers to offer plans covering certain percentages of the cost of covered benefits; and a younger mix of enrollees. By 2026, average premiums for single policyholders in the nongroup market under the legislation would be roughly 10 percent lower than under current law, CBO and JCT estimate.

Although average premiums would increase prior to 2020 and decrease starting in 2020, CBO and JCT estimate that changes in premiums relative to those under current law would differ significantly for people of different ages because of a change in age-rating rules. Under the legislation, insurers would be allowed to generally charge five times more for older enrollees than younger ones rather than three times more as under current law, substantially reducing premiums for young adults and substantially raising premiums for older people.

Uncertainty Surrounding the Estimates

The ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to the changes made by the legislation are all difficult to predict, so the estimates in this report are uncertain. But CBO and JCT have endeavored to develop estimates that are in the middle of the distribution of potential outcomes.

Macroeconomic Effects

Because of the magnitude of its budgetary effects, this legislation is "major legislation," as defined in the rules of the House of Rep-

representatives.¹ Hence, it triggers the requirement that the cost estimate, to the greatest extent practicable, include the budgetary impact of its macroeconomic effects. However, because of the very short time available to prepare this cost estimate, quantifying and incorporating those macroeconomic effects have not been practicable.

Intergovernmental and Private-Sector Mandates

JCT and CBO have reviewed the provisions of the legislation and determined that they would impose no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA).

JCT and CBO have determined that the legislation would impose private-sector mandates as defined in UMRA. On the basis of information from JCT, CBO estimates the aggregate cost of the mandates would exceed the annual threshold established in UMRA for private-sector mandates (\$156 million in 2017, adjusted annually for inflation).

MAJOR PROVISIONS OF THE LEGISLATION

Budgetary effects related to health insurance coverage would stem primarily from the following provisions:

- Eliminating penalties associated with the requirements that most people obtain health insurance coverage and that large employers offer their employees coverage that meets specified standards.
- Reducing the federal matching rate for adults made eligible for Medicaid by the ACA to equal the rate for other enrollees in the state, beginning in 2020.
- Capping the growth in per-enrollee payments for most Medicaid beneficiaries to no more than the medical care component of the consumer price index starting in 2020.
- Repealing current-law subsidies for health insurance coverage obtained through the nongroup market—which include refundable tax credits for premium assistance and subsidies to reduce cost-sharing payments—as well as the Basic Health Program, beginning in 2020.
- Creating a new refundable tax credit for health insurance coverage purchased through the nongroup market beginning in 2020.
- Appropriating funding for grants to states through the Patient and State Stability Fund beginning in 2018.
- Relaxing the current-law requirement that prevents insurers from charging older people premiums that are more than three times larger than the premiums charged to younger people in the nongroup and small-group markets. Unless a state sets a different limit, the legislation would allow insurers to charge older people five times more than younger ones, beginning in 2018.

¹ Cl. 8 of Rule XIII of the Rules of the House of Representatives, H.R. Res. 5, 115th Congress (2017).

- Removing the requirement, beginning in 2020, that insurers who offer plans in the nongroup and small-group markets generally must offer plans that cover at least 60 percent of the cost of covered benefits.
- Requiring insurers to apply a 30 percent surcharge on premiums for people who enroll in insurance in the nongroup or small-group markets if they have been uninsured for more than 63 days within the past year.

Other parts of the legislation would repeal or delay many of the changes the ACA made to the Internal Revenue Code that were not directly related to the law's insurance coverage provisions. Those with the largest budgetary effects include:

- Repealing the surtax on certain high-income taxpayers' net investment income;
- Repealing the increase in the Hospital Insurance payroll tax rate for certain high-income taxpayers;
- Repealing the annual fee on health insurance providers; and
- Delaying when the excise tax imposed on some health insurance plans with high premiums would go into effect.

In addition, the legislation would make several changes to other health-related programs that would have smaller budgetary effects.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

CBO and JCT estimate that, on net, enacting the legislation would decrease federal deficits by \$337 billion over the 2017–2026 period (see Table 1). That change would result from a \$1.2 trillion decrease in direct spending, partially offset by an \$883 billion reduction in revenues.

BASIS OF ESTIMATE

For this estimate, CBO and JCT assume that the legislation will be enacted by May 2017. Costs and savings are measured relative to CBO's March 2016 baseline projections, with adjustments for legislation that was enacted after that baseline was produced.

The largest budgetary effects would stem from provisions in the recommendations from both committees that would affect insurance coverage. Those provisions, taken together, would reduce projected deficits by \$935 billion over the 2017–2026 period. Other provisions would increase deficits by \$599 billion, mostly by reducing tax revenues. All told, deficits would be reduced by \$337 billion over that period, CBO and JCT estimate. (See Table 2 for the estimated budgetary effects of each major provision.)

Budgetary Effects of Health Insurance Coverage Provisions

The \$935 billion in estimated deficit reduction over the 2017–2026 period that would stem from the insurance coverage provisions includes the following amounts (shown in Table 3):

- A reduction of \$880 billion in federal outlays for Medicaid;

- Savings of \$673 billion, mostly stemming from the elimination of the ACA’s subsidies for nongroup health insurance—which include refundable tax credits for premium assistance and subsidies to reduce cost-sharing payments—in 2020;
- Savings of \$70 billion mostly associated with shifts in the mix of taxable and nontaxable compensation resulting from net decreases in the number of people estimated to enroll in employment-based health insurance coverage; and
- Savings of \$6 billion from the repeal of a tax credit for certain small employers that provide health insurance to their employees.

Those decreases would be partially offset by:

- A cost of \$361 billion for the new tax credit for health insurance established by the legislation in 2020;
- A reduction in revenues of \$210 billion from eliminating the penalties paid by uninsured people and employers;
- An increase in spending of \$80 billion for the new Patient and State Stability Fund grant program; and
- A net increase in spending of \$43 billion under the Medicare program stemming from changes in payments to hospitals that serve a disproportionate share of low-income patients.

Methodology. The legislation would change the pricing of nongroup insurance and the eligibility for and the amount of subsidies to purchase that insurance. It would also lead to changes in Medicaid eligibility and per capita spending. The legislation’s effects on health insurance coverage would depend in part on how responsive individuals are to changes in the prices, after subsidies, they would have to pay for nongroup insurance; on changes in their eligibility for public coverage; and on their underlying desire for such insurance. Effects on coverage would also stem from how responsive firms are to changes in those post subsidy prices and in the attractiveness of other aspects of nongroup alternatives to employment-based insurance.

To capture those complex interactions, CBO uses a microsimulation model to estimate how rates of coverage and sources of insurance would change as a result of alterations in eligibility and subsidies for—and thus the net cost of—various insurance options. Based on survey data, that model incorporates a wide range of information about a representative sample of individuals and families, including their income, employment, health status, and health insurance coverage. The model also incorporates information from the research literature about the responsiveness of individuals and employers to price changes and the responsiveness of individuals to changes in eligibility for public coverage. CBO regularly updates the model so that it incorporates information from the most recent administrative data on insurance coverage and premiums. CBO and JCT use that model—in combination with models of tax revenues, models of Medicaid spending and actions by states, projections of trends in early retirees’ health insurance coverage, and other available information—to inform their estimates of the num-

bers of people with certain types of coverage and the associated federal budgetary costs.²

Effects of Repealing Mandate Penalties. Eliminating the penalties associated with two requirements, while keeping the requirements themselves in place, would affect insurance coverage in various ways. Those two requirements are that most people obtain health insurance coverage (also called the individual mandate) and that large employers offer their employees health insurance coverage that meets specified standards (also called the employer mandate). Eliminating their associated penalties would reduce federal revenues starting in 2017, but CBO and JCT estimate that doing so would also substantially reduce the number of people with health insurance coverage and, accordingly, would reduce the costs incurred by the federal government in subsidizing some health insurance coverage. The estimated savings stemming from fewer people enrolling in Medicaid, in health insurance obtained through the nongroup market, and in employment-based health insurance coverage would exceed the estimated loss of revenues from eliminating mandate penalties.

CBO and JCT estimate that repealing the individual mandate penalties would also result in higher health insurance premiums in the nongroup market after 2017.³ Insurers would still be required to provide coverage to any applicant, would not be able to vary premiums to reflect enrollees' health status or to limit coverage of pre-existing medical conditions, and would be limited in how premiums could vary by age. Those features are most attractive to applicants with relatively high expected costs for health care, so CBO and JCT expect that repealing the individual mandate penalties would tend to reduce insurance coverage less among older and less healthy people than among younger and healthier people. Thus, the agencies estimate that repealing those penalties, taken by itself, would increase premiums. Nevertheless, CBO and JCT anticipate that a significant number of relatively healthy people would still purchase insurance in the nongroup market because of the availability of government subsidies.

Major Changes to Medicaid. CBO estimates that several major provisions affecting Medicaid would decrease direct spending by \$880 billion over the 2017–2026 period. That reduction would stem primarily from lower enrollment throughout the period, culminating in 14 million fewer Medicaid enrollees by 2026, a reduction of about 17 percent relative to the number under current law. Some of that decline would be among people who are currently eligible for Medicaid benefits, and some would be among people who CBO projects would be made eligible as a result of state actions in the future under current law (that is, from additional states adopting the optional expansion of eligibility authorized by the ACA). Some decline in spending and enrollment would begin immediately, but most of the changes would begin in 2020, when the legislation would terminate the enhanced federal matching rate for new en-

²For additional information, see Congressional Budget Office, "Methods for Analyzing Health Insurance Coverage" (accessed March 13, 2017), www.cbo.gov/topics/health-care/methods-analyzing-health-insurance-coverage.

³CBO and JCT expect that insurers would not be able to change their 2017 premiums because those premiums have already been set.

rollees under the ACA's expansion of Medicaid and would place a per capita-based cap on the federal government's payments to states for medical assistance provided through Medicaid. By 2026, Medicaid spending would be about 25 percent less than what CBO projects under current law.

Changes Before 2020. Under current law, the penalties associated with the individual mandate apply to some Medicaid-eligible adults and children. (For example, the penalties apply to single individuals with income above about 90 percent of the federal poverty guidelines, also known as the federal poverty level, or FPL). CBO estimates that, without those penalties, fewer people would enroll in Medicaid, including some who are not subject to the penalties but might think they are. Some people might be uncertain about what circumstances trigger the penalty and others might be uncertain about their annual income. The estimated lower enrollment would result in less spending for the program. Those effects on enrollment and spending would continue throughout the 2017–2026 period.

Termination of Enhanced Federal Matching Funds for New Enrollees From Expanding Eligibility for Medicaid. Under current law, states are permitted, but not required, to expand eligibility for Medicaid to adults under 65 whose income is equal to or less than 138 percent of the FPL (referred to here as “newly eligible”). The federal government pays a larger share of the medical costs for those people than it pays for those who were previously eligible. Beginning in 2020, the legislation would reduce the federal matching rate for newly eligible adults from 90 percent of medical costs to the rate for other enrollees in the state. (The federal matching rate for other enrollees ranges from 50 percent to 75 percent, depending on the state, with an average of about 57 percent.) The lower federal matching rate would apply only to those newly enrolled after December 31, 2019.

The 31 states and the District of Columbia that have already expanded Medicaid to the newly eligible cover roughly half of that population nationwide. CBO projects that under current law, additional states will expand their Medicaid programs and that, by 2026, roughly 80 percent of newly eligible people will reside in states that have done so. Under the legislation, largely because states would pay for a greater share of enrollees' costs, CBO expects that no additional states would expand eligibility, thereby reducing both enrollment in and spending for Medicaid. According to CBO's estimates, that effect would be modest in the near term, but by 2026, on an average annual basis, 5 million fewer people would be enrolled in Medicaid than would have been enrolled under current law (see Figure 1).

CBO also anticipates some states that have already expanded their Medicaid programs would no longer offer that coverage, reducing the share of the newly eligible population residing in a state with expanded eligibility to about 30 percent in 2026. That estimate reflects different possible outcomes without any explicit prediction about which states would make which choices. In considering the possible outcomes, CBO took into account several factors: the extent of optional coverage provided to the newly eligible popu-

lation and other groups before the ACA's enactment (as a measure of a state's willingness to provide coverage above statutory minimums), states' ability to bear costs under the legislation, and potential methods to mitigate those costs (such as changes to benefit packages and payment rates). Some states might also begin to take action prior to 2020 in anticipation of future changes that would result from the legislation to avoid abrupt changes to eligibility and other program features. How individual states would ultimately respond is highly uncertain.

Because the lower federal matching rate would apply only to those newly enrolled after December 31, 2019 (or who experience a break in eligibility after that date), CBO estimates that reductions in spending for the newly eligible would increase over several years, as "grandfathered" enrollees would cycle off the program and be replaced by new enrollees. On the basis of historical data (and taking into account the increased frequency of eligibility redeterminations required by the legislation), CBO projects that fewer than one-third of those enrolled as of December 31, 2019, would have maintained continuous eligibility two years later. Under the legislation, the higher federal matching rate would apply for fewer than 5 percent of newly eligible enrollees by the end of 2024, CBO estimates.

Per Capita-Based Cap on Medicaid Payments for Medical Assistance. Under current law, the federal government and state governments share in the financing and administration of Medicaid. In general, states pay health care providers for services to enrollees, and the federal government reimburses states for a percentage of their expenditures. All federal reimbursement for medical services is open-ended, meaning that if a state spends more because enrollment increases or costs per enrollee rise, additional federal payments are automatically generated.

Under the legislation, beginning in 2020, the federal government would establish a limit on the amount of reimbursement it provides to states. That limit would be set by calculating the average per-enrollee cost of medical services for most enrollees who received full Medicaid benefits in 2016 for each state. The Secretary of Health and Human Services would then inflate the average per-enrollee costs for each state by the growth in the consumer price index for medical care services (CPI-M). The final limit on federal reimbursement for each state for 2020 and after would be the average cost per enrollee for five specified groups of enrollees (the elderly, disabled people, children, newly eligible adults, and all other adults), reflecting growth in the CPI-M from 2016 multiplied by the number of enrollees in each category in that year. If a state spent more than the limit on federal reimbursement, the federal government would provide no additional funding to match that spending.

The limit on federal reimbursement would reduce outlays because (after the changes to the Medicaid expansion population have been accounted for) Medicaid spending would grow on a per-enrollee basis at a faster rate than the CPI-M, according to CBO's projections: at an average annual rate of 4.4 percent for Medicaid and 3.7 percent for the CPI-M over the 2017–2026 period. With less federal reimbursement for Medicaid, states would need to de-

cide whether to commit more of their own resources to finance the program at current-law levels or whether to reduce spending by cutting payments to health care providers and health plans, eliminating optional services, restricting eligibility for enrollment, or (to the extent feasible) arriving at more efficient methods for delivering services. CBO anticipates that states would adopt a mix of those approaches, which would result in additional savings to the federal government. (Other provisions affecting Medicaid are discussed below.)

Changes to Subsidies and Market Rules for Nongroup Health Insurance Before 2020. Under the legislation, existing subsidies for health insurance coverage purchased in the nongroup market would largely remain in effect until 2020—but the premium tax credits would differ by the age of the individual in 2019. Aside from the changes in enrollment and premiums as a result of eliminating the individual mandate penalties (mentioned earlier), the other changes discussed in this section would have small effects on coverage and federal subsidies in the nongroup market.

Nongroup Market Subsidies. Subsidies under current law fall into two categories: subsidies to cover a portion of participants' health insurance premiums (which take the form of refundable tax credits) and subsidies to reduce their cost-sharing amounts (out-of-pocket payments required under insurance policies). The first category of subsidies, also called premium tax credits, is generally available to people with income between 100 percent and 400 percent of the FPL, with certain exceptions. The second category, also called cost-sharing subsidies, is available to those who are eligible for premium tax credits, generally have a household income between 100 percent and 250 percent of the FPL, and enroll in an eligible plan.

Under current law, those subsidies can be obtained only by purchasing nongroup coverage through a health insurance marketplace. Under the legislation, premium tax credits—but not cost-sharing subsidies—would also be available for most plans purchased in the nongroup market outside of marketplaces beginning in 2018. However, the tax credits for those plans could not be advanced and could only be claimed on a person's tax return. CBO and JCT estimate that roughly 2 million people who are expected to enroll in plans purchased in the nongroup market outside of marketplaces in 2018 and 2019 under current law would newly receive premium tax credits for that coverage under the legislation.

The premium tax credits would differ by the age of the individual for one year in 2019, while cost-sharing subsidies would remain unchanged prior to 2020. For those with household income exceeding 150 percent of the FPL, the legislation would generally reduce the percentage of income that younger people had to pay toward their premiums and increase that percentage for older people.⁴ CBO and JCT expect that roughly 1 million more people would enroll in cov-

⁴ For families, the age of the oldest taxpayer would be used to determine the age-adjusted percentage of income that must be paid toward the premiums. As under current law, the premium tax credits would cover the amount by which the reference premium—that is, the premium for the second-lowest-cost “silver” plan that covers the eligible people in the household in the area in which they reside—exceeds that percentage of income. A silver plan covers about 70 percent of the costs of covered benefits.

erage obtained through the nongroup market as a result of the change in the structure of premium tax credits. That increase would be the net result of higher enrollment among younger people and lower enrollment among older people.

Patient and State Stability Fund Grants. Beginning in 2018 and ending after 2026, the federal government would make a total of \$100 billion in allotments to states that they could use for a variety of purposes, including reducing premiums for insurance in the nongroup market. CBO and JCT estimate that federal outlays for grants from the Patient and State Stability Fund would total \$80 billion over the 2018–2026 period.

By the agencies' estimates, the grants would reduce premiums for insurance in the nongroup market in many states. CBO and JCT expect that states would use those grants mostly to reimburse insurers for some of the costs of enrollees with claims above a threshold. For states that did not develop plans to spend the funds, the federal government would make payments to insurers in the individual market who have enrollees with relatively high claims. Before 2020, CBO expects, the Secretary of Health and Human Services would make payments to insurers on the behalf of most states because most would not have enough time to set up their own programs before insurers had to set premiums for 2018. As a result, CBO estimates that most states would rely on the federal default program for one or more years until they had more time to establish their own programs.

Continuous Coverage Provisions. Insurers would be required to impose a penalty on people who enrolled in insurance in the nongroup or small-group markets if they had been uninsured for more than 63 days within the past year. When they purchased insurance in the nongroup or small-group market, they would be subject to a surcharge equal to 30 percent of their monthly premium for up to 12 months. The requirement would apply to people enrolling during a special enrollment period in 2018 and, beginning in 2019, to people enrolling at any time during the year.

CBO and JCT expect that increasing the future price of insurance through the surcharge for people who do not have continuous coverage would increase the number of people with insurance in 2018 and reduce that number in 2019 and later years. By the agencies' estimates, roughly 1 million people would be induced to purchase insurance in 2018 to avoid possibly having to pay the surcharge in the future. In most years after 2018, however, roughly 2 million fewer people would purchase insurance because they would either have to pay the surcharge or provide documentation about previous health insurance coverage. The people deterred from purchasing coverage would tend to be healthier than those who would not be deterred and would be willing to pay the surcharge.

Age Rating Rules. Beginning in 2018, the legislation would expand the limits on how much insurers in the nongroup and small-group markets can vary premiums on the basis of age. However, CBO and JCT expect that the provision could not be implemented until 2019 because there would be insufficient time for the federal government, states, and insurers to incorporate the changes and

then set premiums for 2018. Under current law, a 64-year-old can generally be charged premiums that cost up to three times as much as those offered to a 21-year-old. Under the legislation, that allowable difference would shift to five times as much unless a state chose otherwise. That change would tend to reduce premiums for younger people and increase premiums for older people.

However, CBO and JCT estimate that the structure of the premium tax credits before 2020 would limit how changes in age rating rules affected the number of people who would enroll in health insurance coverage in the nongroup market. People eligible for subsidies in the nongroup market are now largely insulated from changes in premiums: A person receiving a premium tax credit pays a certain percentage of his or her income toward the reference premium, and the tax credit covers the difference between the premium and that percentage of income. Consequently, despite the changes in premiums for younger and older people, the person's out-of-pocket payments would not be affected much. Therefore, CBO and JCT estimate that the increase in the number of people enrolled in coverage through the nongroup market as a result of changes in age rating rules would be less than 500,000 in 2019 and would be the net result of higher enrollment among younger people and lower enrollment among older people. The small increase would mostly stem from net changes in enrollment among people who had income high enough to be ineligible for subsidies and who would face substantial changes in out-of-pocket payments for premiums.

Changes to Subsidies and Market Rules for Nongroup Health Insurance Beginning in 2020. Beginning in 2020, the current premium tax credits and cost-sharing subsidies would both be repealed. That same year, the legislation would create new refundable tax credits for insurance purchased in the nongroup market. In addition to making the market changes discussed thus far (eliminating mandate penalties, providing grants to states to help stabilize the nongroup market, establishing a requirement for continuous coverage, and changing the age rating rules), the legislation would relax the current requirements about the share of benefits that must be covered by a health insurance plan.

Many rules governing the nongroup market would remain in effect as under current law. For example, insurers would be required to accept all applicants during specified open-enrollment periods, could not vary people's premiums on the basis of their health, and could not restrict coverage of enrollees' preexisting health conditions. Insurers would also still be required to cover specified categories of health care services, and the amount of costs for covered services that enrollees have to pay out of pocket would remain limited to a specified threshold. Prohibitions on annual and lifetime maximum benefits would still apply. Also, the risk adjustment program—which transfers funds from plans that attract a relatively small proportion of high-risk enrollees (people with serious chronic conditions, for example) to plans that attract a relatively large proportion of such people—would remain in place.

Because the new tax credits are designed primarily to be paid in advance on behalf of enrollees to insurers, procedures would need to be in place to enable the Internal Revenue Service and the De-

partment of Health and Human Services to verify that the credits were being paid to eligible insurers who were offering qualified insurance as defined under federal and state law on behalf of eligible enrollees. CBO and JCT's estimates reflect an assumption that adequate resources would be made available through future appropriations to those executive branch agencies to ensure that such systems were put in place in a timely manner. To the extent that they were not, enrollment and compliance could be negatively affected.

Changes to Actuarial Value Requirements. Actuarial value is the percentage of total costs for covered benefits that the plan pays when covering a standard population. Under current law, most plans in the nongroup and small-group markets must have an actuarial value that is in one of four tiers: about 60 percent, 70 percent, 80 percent, or 90 percent. Beginning in 2020, the legislation would repeal those requirements, potentially allowing plans to have an actuarial value below 60 percent. However, plans would still be required to cover 10 categories of health benefits that are defined as "essential" under current law, and the total annual out-of-pocket costs for an enrollee would remain capped. In CBO and JCT's estimation, complying with those two requirements would significantly limit the ability of insurers to design plans with an actuarial value much below 60 percent.

Nevertheless, CBO and JCT estimate that repealing the actuarial value requirements would lower the actuarial value of plans in the nongroup market on average. The requirement that insurers offer both a plan with an actuarial value of 70 percent and one with an actuarial value of 80 percent in order to participate in the marketplace would no longer apply under the legislation. As a result, an insurer could choose to sell only plans with lower actuarial values. Many insurers would find that option attractive because they could offer a plan priced closer to the amount of the premium tax credit so that a younger person would have low out-of-pocket costs for premiums and would be more likely to enroll. Insurers might be less likely to offer plans with high actuarial values out of a fear of attracting a greater proportion of less healthy enrollees to those plans, although the availability of the Patient and State Stability Fund grants in most states would reduce that risk. The continuation of the risk adjustment program could also help limit insurers' costs from high-risk enrollees.

Because of plans' lower average actuarial values, CBO and JCT expect that individuals' cost-sharing payments, including deductibles, in the nongroup market would tend to be higher than those anticipated under current law. In addition, cost-sharing subsidies would be repealed in 2020, significantly increasing out-of-pocket costs for nongroup insurance for many lower-income enrollees. The higher costs would make the plans less attractive than those available under current law to many potential enrollees, especially people who are eligible for the largest subsidies under current law.

Changes in the Ways the Nongroup Market Would Function. Under the legislation, some of the ways that the nongroup market functions would change for consumers. The current actuarial value

requirements help people compare different insurance plans, because all plans in a tier cover the same share of costs, on average. CBO and JCT expect that, under the legislation, plans would be harder to compare, making shopping for a plan on the basis of price more difficult.

Another feature of the nongroup market under current law is that there is one central website through the state or federal marketplace where people can shop for all the plans in their area that are eligible for subsidies. Under the legislation, insurers participating in the nongroup market would no longer have to offer plans through the marketplaces in order for people to receive subsidies toward those plans; therefore, CBO and JCT estimate that fewer would do so. With more plans that are eligible for subsidies offered directly from insurers or directly through agents and brokers and not through the marketplaces' central websites, shopping for and comparing plans could be harder, depending on insurers' decisions about how to market their plans.

Changes in Nongroup Market Subsidies. With the repeal in 2020 of the current premium tax credits and the cost-sharing subsidies, different refundable tax credits for insurance purchased in the nongroup market would become available.⁵ The new tax credits would vary on the basis of age by a factor of 2 to 1: Someone age 60 or older would be eligible for a tax credit of \$4,000, while someone younger than age 30 would be eligible for a tax credit of \$2,000. People would generally be eligible for the full amount of the tax credit if their adjusted gross income was below \$75,000 for a single tax filer and below \$150,000 for joint filers and if they were not eligible for certain other types of insurance coverage.⁶ The credits would phase out for people with income above those thresholds. The tax credits would be refundable if the size of the credit exceeded a person's tax liability. They could also be advanced to insurers on a monthly basis throughout the year on behalf of an enrollee. Finally, tax credits could be used for most health insurance plans purchased through a marketplace or directly from an insurer.

Under current law, the size of the premium tax credit depends on household income and the reference premium in an enrollee's rating area. The enrollee pays a certain percentage of his or her income toward the reference premium, and the size of the subsidy varies by geography and age for a given income level. In that way, the enrollee is insulated from variations in premiums by geography and is also largely insulated from increases in the reference premium. An enrollee would pay the difference between the reference premium and the premium for the plan he or she chose, providing some incentive to choose lower-priced insurance. Beginning in 2020, under the legislation, the size of a premium tax credit would vary with age, rather than with income (except for people with income in the phase-out range) or the amount of the premium. The enrollee would be responsible for any premium above the credit amount. That structure would provide greater incentives for enrollees to choose lower-priced insurance and would mean that people

⁵People would also be able to use the new tax credits toward unsubsidized continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

⁶The tax credits and the income thresholds would both be indexed each year by the consumer price index for all urban consumers plus 1 percentage point.

living in high-cost areas would be responsible for a larger share of the premium.

Under the legislation, some people would be eligible for smaller subsidies than those under current law, and others would be eligible for larger ones. As a result, by CBO and JCT's estimates, the composition of the population purchasing health insurance in the nongroup market under the legislation would differ significantly from that under current law, particularly by income and age.

For many lower-income people, the new tax credits under the legislation would tend to be smaller than the premium tax credits under current law.⁷ In an illustrative example, CBO and JCT estimate that a 21-year-old with income at 175 percent of the FPL in 2026 would be eligible for a premium tax credit of about \$3,400 under current law; the tax credit would fall to about \$2,450 under the legislation (see Table 4). In addition, because cost-sharing subsidies would be eliminated under the legislation, lower-income people's share of medical services paid in the form of deductibles and other cost sharing would increase. As a result, CBO and JCT estimate, fewer lower-income people would obtain coverage through the nongroup market under the legislation than under current law.

Conversely, the tax credits under the legislation would tend to be larger than current-law premium tax credits for many people with higher income—particularly for those with income above 400 percent of the FPL but below the income cap for a full credit, which is set by the legislation at \$75,000 for a single tax filer and \$150,000 for joint filers in 2020. For example, CBO and JCT estimate that a 21-year-old with income at 450 percent of the FPL in 2026 would be ineligible for a credit under current law but newly eligible for a tax credit of about \$2,450 under the legislation. Lower out-of-pocket payments toward premiums would tend to increase enrollment in the nongroup market among higher-income people.

Enacting the legislation would also result in significant changes in the size of subsidies in the nongroup market according to people's age. For example, CBO and JCT estimate that a 21-year-old, 40-year-old, and 64-year-old with income at 175 percent of the FPL in 2026 would all pay roughly \$1,700 toward their reference premium under current law, even though the reference premium for a 64-year-old is three times larger than that for a 21-year-old in most states. Under the legislation, premiums for older people could be five times larger than those for younger people in many states, but the size of the tax credits for older people would only be twice the size of the credits for younger people. Because of that difference in how much the tax credits would cover, CBO and JCT estimate that, under the legislation, a larger share of enrollees in the nongroup market would be younger people and a smaller share would be older people.

According to CBO and JCT's estimates, total federal subsidies for nongroup health insurance would be significantly smaller under the legislation than under current law for two reasons. First, by the agencies' projections, fewer people, on net, would obtain coverage in the nongroup health insurance market under the legisla-

⁷ People with income below 100 percent of the FPL who are ineligible for Medicaid and meet other eligibility criteria would become newly eligible for a premium tax credit under the legislation.

tion. Second, the average subsidy per subsidized enrollee under the legislation would be significantly lower than the average subsidy under current law. In 2020, CBO and JCT estimate, the average subsidy under the legislation would be about 60 percent of the average subsidy under current law. In addition, the average subsidy would grow more slowly under the legislation than under current law. That difference results from the fact that subsidies under current law tend to grow with insurance premiums, whereas subsidies under the legislation would grow more slowly, with the consumer price index for all urban consumers plus 1 percentage point. By 2026, CBO and JCT estimate that the average subsidy under the legislation would be about 50 percent of the average subsidy under current law.

Patient and State Stability Fund Grants. As a condition of the grants, beginning in 2020, states would be required to provide matching funds, which would generally increase from 7 percent of the federal funds provided in 2020 to 50 percent of the federal funds provided in 2026. The agencies expect that the grants' effects on premiums after 2020 would be limited by the share of states that took action and decided to pay the required matching funds in order to receive federal money and by the extent to which states chose to use the money for purposes that did not directly help to lower premiums in the nongroup market. Nevertheless, CBO and JCT estimate that the grants would exert substantial downward pressure on premiums in the nongroup market in 2020 and later years and would help encourage participation in the market by insurers.

Effects of Changes in the Nongroup Market on Employers' Decisions to Offer Coverage. CBO and JCT estimate that, over time, fewer employers would offer health insurance because the legislation would change their incentives to do so. First, the mandate penalties would be eliminated. Second, the tax credits under the legislation, for which people would be ineligible if they had any offer of employment-based insurance, would be available to people with a broader range of incomes than the current tax credits are. That change could make nongroup coverage more attractive to a larger share of employees. Consequently, in CBO and JCT's estimation, some employers would choose not to offer coverage and instead increase other forms of compensation in the belief that nongroup insurance was a close substitute for employment-based coverage for their employees.

However, two factors would partially offset employers' incentives not to offer insurance. First, the average subsidy for those who are eligible would be smaller under the legislation than under current law and would grow more slowly than health care costs over time. Second, CBO and JCT anticipate, nongroup insurance under the legislation would be less attractive to many people with employment-based coverage than under current law because nongroup insurance under the legislation would cover a smaller share of enrollees' expenses, on average, and because shopping for and comparing plans would probably be more difficult. In general, CBO and JCT expect that businesses that decided not to offer insurance coverage under the legislation would have, on average, younger and higher-

income workforces than businesses that choose not to offer insurance under current law.

CBO and JCT expect that employers would adapt slowly to the legislation. Some employers would probably delay making decisions because of uncertainty about the viability of and regulations for the nongroup market and about implementation of the new law.

Market Stability. CBO and JCT anticipate that, under the legislation, the combination of subsidies to purchase nongroup insurance and rules regulating the market would result in a relatively stable nongroup market. That is, most areas of the country would have insurers participating in the nongroup market, and the market would not be subject to an unsustainable spiral of rising premiums. First and most important, a substantial number of relatively healthy (mostly young) people would continue to purchase insurance in the nongroup market because of the availability of government subsidies. Second, grants from the Patient and State Stability Fund would help stabilize premiums and reduce potential losses to insurers from enrollees with very large claims. Finally, in CBO and JCT's judgment, the risk adjustment program would help protect insurers from losses arising from high-risk enrollees. The agencies expect that all of those factors would encourage insurers to continue to participate in the nongroup market.

However, significant changes in nongroup subsidies and market rules would occur each year for the first three years following enactment, which might cause uncertainty for insurers in setting premiums. As a result of the elimination of the individual mandate penalties, CBO and JCT project that nongroup enrollment in 2018 would be smaller than that in 2017 and that the average health status of enrollees would worsen. A small share of that decline in enrollment would be offset by the onetime effect of the continuous coverage provisions, which would somewhat increase enrollment in the nongroup market in 2018 as people anticipated potential surcharges in 2019. Grants from the Patient and State Stability Fund would begin to take effect in 2018 to help mitigate losses and encourage participation by insurers.

The mix of enrollees in 2019 would differ from that in 2018, because the change to age-rating rules would allow older adults to be charged five times as much as younger adults in many states. In addition, there would be a one-year change to the premium tax credits, which CBO and JCT expect would somewhat increase enrollment among younger adults and decrease enrollment among older adults. Although the combined effect of those two changes would reduce the average age and improve the average health of enrollees in the nongroup market, it might be difficult for insurers to set premiums for 2019 using their prior experience in the market.

In 2020, CBO estimates, grants to states from the Patient and State Stability Fund, once fully implemented, would significantly reduce premiums in the nongroup market and encourage participation by insurers. The grants would help to reduce the risk to insurers of offering nongroup insurance. As a result, CBO expects that those grants would contribute substantially to the stability of the nongroup market.

That effect would occur despite the fact that more major changes taking effect in that year would make it difficult for insurers to predict the mix of enrollees on the basis of their recent experience. The new age-based tax credits would be introduced in 2020 and actuarial value requirements would be eliminated. In response, insurers would have the flexibility to sell different types of plans than they do under current law. The nongroup market is expected to be smaller in 2020 than in 2019 but then is expected to grow somewhat over the 2020–2026 period.

Other Budgetary Effects of Health Insurance Coverage Provisions. Because the insurance coverage provisions of the legislation would increase the number of uninsured people and decrease the number of people with Medicaid coverage relative to the numbers under current law, CBO estimates that Medicare spending would increase by \$43 billion over the 2018–2026 period.

Medicare makes additional “disproportionate share hospital” payments to facilities that serve a higher percentage of uninsured patients. Those payments have two components: an increase to the payment rate for each inpatient case and a lump-sum allocation of a pool of funds based on each qualifying hospital’s share of the days of care provided to beneficiaries of Supplemental Security Income and Medicaid.

Under the legislation, the decreased enrollment in Medicaid would slightly reduce the amounts paid to hospitals, CBO estimates. However, the increase in the number of uninsured people would substantially boost the amounts distributed on a lump-sum basis.

Net Effects on Health Insurance Coverage

CBO and JCT expect that under the legislation, the number of people without health insurance coverage would increase but that the increase would be limited initially, because insurers have already set their premiums for the current year and many people have already made their enrollment decisions for the year. However, in 2017, the elimination of the individual mandate penalties would result in about 4 million additional people becoming uninsured (see Table 5).

In 2018, by CBO and JCT’s estimates, about 14 million more people would be uninsured, relative to the number under current law. That increase would consist of about 6 million fewer people with coverage obtained in the nongroup market, roughly 5 million fewer people with coverage under Medicaid, and about 2 million fewer people with employment-based coverage. In 2019, the number of uninsured would grow to 16 million people because of further reductions in Medicaid and nongroup coverage. Most of the reductions in coverage in 2018 and 2019 would stem from repealing the penalties associated with the individual mandate. Some of those people would choose not to have insurance because they choose to be covered by insurance under current law only to avoid paying the penalties. And some people would forgo insurance in response to higher premiums. CBO and JCT estimate that, in total, 41 million people under age 65 would be uninsured in 2018 and 43 million people under age 65 would be uninsured in 2019.

In 2020, according to CBO and JCT's estimates, as a result of the insurance coverage provisions of the legislation, 21 million more nonelderly people in the United States would be without health insurance than under current law. By 2026, that number would total 24 million, CBO and JCT estimate. Specifically:

- Roughly 9 million fewer people would enroll in Medicaid in 2020; that figure would rise to 14 million in 2026, as states that expanded eligibility for Medicaid discontinued doing so, as states projected to expand Medicaid in the future chose not to do so, and as the cap on per-enrollee spending took effect.
- Roughly 9 million fewer people, on net, would obtain coverage through the nongroup market in 2020; that number would fall to 2 million in 2026. The reduction in enrollment in the nongroup market would shrink over the 2020–2026 period because people would gain experience with the new structure of the tax credits and some employers would respond to those tax credits by declining to offer insurance to their employees.
- Roughly 2 million fewer people, on net, would enroll in employment-based coverage in 2020, and that number would grow to roughly 7 million in 2026. Part of that net reduction in employment-based coverage would occur because fewer employees would take up the offer of such coverage in the absence of the individual mandate penalties. In addition, CBO and JCT expect that, over time, fewer employers would offer health insurance to their workers.

CBO and JCT estimate that 48 million people under age 65, or roughly 17 percent of the nonelderly population, would be uninsured in 2020 if the legislation was enacted. That figure would grow to 52 million, or roughly 19 percent of the nonelderly population, in 2026. (That figure is currently about 10 percent and is projected to remain at that level in each year through 2026 under current law.) Although the agencies expect that the legislation would increase the number of uninsured broadly, the increase would be disproportionately larger among older people with lower income; in particular, people between 50 and 64 years old with income of less than 200 percent of the FPL would make up a larger share of the uninsured (see Figure 2).

Net Effects on Health Insurance Premiums

The legislation would tend to increase average premiums in the nongroup market prior to 2020 and lower average premiums thereafter, relative to the outcomes under current law. (This discussion is focused on premiums before any applicable tax credits and before any surcharges for not maintaining continuous coverage.)

In 2018 and 2019, according to CBO and JCT's estimates, average premiums for single policyholders in the nongroup market would be 15 percent to 20 percent higher than under current law mainly because of the elimination of the individual mandate penalties. Eliminating those penalties would markedly reduce enrollment in the nongroup market and increase the share of enrollees who would be less healthy. CBO and JCT expect that grants from the Patient and State Stability Fund would largely be used for re-

insurance programs, particularly in 2018 and 2019, when many states would rely on the federal default before establishing their own programs and, as explained earlier, that those payments would help lower premiums in the nongroup market. The agencies estimate that program would have a relatively small effect on premiums in 2018 because there would not be much time between enactment of the legislation and insurers' deadlines for setting premiums for 2018. By 2019, however, in CBO and JCT's judgment, the Patient and State Stability Fund would have the effect of somewhat moderating the increases in average premiums in the nongroup market resulting from the legislation.

Starting in 2020, the increase in average premiums from repealing the individual mandate penalties would be more than offset by the combination of three main factors. First, the mix of people enrolled in coverage obtained in the nongroup market is anticipated to be younger, on average, than the mix under current law. Second, premiums, on average, are estimated to fall because of the elimination of actuarial value requirements, which would result in plans that cover a lower share of health care costs, on average. Third, reinsurance programs supported by the Patient and State Stability Fund are estimated to reduce premiums. If those funds were devoted to other purposes, then premium reductions would be smaller. By 2026, average premiums for single policyholders in the nongroup market under the legislation would be roughly 10 percent lower than the estimates under current law.

The changes in premiums would vary for people of different ages. The change in age-rating rules, effective in 2019, would directly change the premiums faced by different age groups, substantially reducing premiums for young adults and raising premiums for older people. By 2026, CBO and JCT project, premiums in the nongroup market would be 20 percent to 25 percent lower for a 21-year-old and 8 percent to 10 percent lower for a 40-year-old—but 20 percent to 25 percent higher for a 64-year-old.

Revenue Effects of Other Provisions

JCT estimates that the legislation would reduce revenues by \$592 billion over the 2017–2026 period as a result of provisions that would repeal many of the revenue-related provisions of the ACA (apart from provisions related to health insurance coverage discussed above). Those with the most significant budgetary effects include an increase in the Hospital Insurance payroll tax rate for high-income taxpayers, a surtax on those taxpayers' net investment income, and annual fees imposed on health insurers.⁸

Direct Spending Effects of Other Provisions

The legislation would also make changes to spending for other federal health care programs. CBO and JCT estimate that those provisions would increase direct spending by about \$7 billion over the 2017–2026 period.

⁸JCT published 10 documents (JCX–7–17 through JCX–16–17) on March 7, 2017, relating to the legislation. For more information, see www.jct.gov/publications.html.

Prevention and Public Health Fund. The legislation would, beginning in fiscal year 2019, repeal the provision that established the Prevention and Public Health Fund and rescind all unobligated balances. The Department of Health and Human Services awards grants through the fund to public and private entities to carry out prevention, wellness, and public health activities. Funding under current law is projected to be \$1 billion in 2017 and to rise to \$2 billion in 2025 and each year thereafter. CBO estimates that eliminating that funding would reduce direct spending by \$9 billion over the 2017–2026 period.

Community Health Center Program. The legislation would increase the funds available to the Community Health Center Program, which provides grant funds to health centers that offer primary and preventive care to patients regardless of their ability to pay. Under current law, the program will receive about \$4 billion in fiscal year 2017. The legislation would increase funding for the program by \$422 million in fiscal year 2017. CBO estimates that implementing the provision would increase direct spending by \$422 million over the 2017–2026 period.

Provision Affecting Planned Parenthood. For a one-year period following enactment, the legislation would prevent federal funds from being made available to an entity (including its affiliates, subsidiaries, successors, and clinics) if it is:

- A nonprofit organization described in section 501(c)(3) of the Internal Revenue Code and exempt from tax under section 501(a) of the code;
- An essential community provider that is primarily engaged in providing family planning and reproductive health services and related medical care;
- An entity that provides abortions—except in instances in which the pregnancy is the result of an act of rape or incest or the woman’s life is in danger; and
- An entity that had expenditures under the Medicaid program that exceeded \$350 million in fiscal year 2014.

CBO expects that, according to those criteria, only Planned Parenthood Federation of America and its affiliates and clinics would be affected. Most federal funds received by such entities come from payments for services provided to enrollees in states’ Medicaid programs. CBO estimates that the prohibition would reduce direct spending by \$178 million in 2017 and by \$234 million over the 2017–2026 period. Those savings would be partially offset by increased spending for other Medicaid services, as discussed below.

To the extent that there would be reductions in access to care under the legislation, they would affect services that help women avert pregnancies. The people most likely to experience reduced access to care would probably reside in areas without other health care clinics or medical practitioners who serve low-income populations. CBO projects that about 15 percent of those people would lose access to care.

The government would incur some costs for Medicaid beneficiaries currently served by affected entities because the costs of

about 45 percent of all births are paid for by the Medicaid program. CBO estimates that the additional births stemming from the reduced access under the legislation would add to federal spending for Medicaid. In addition, some of those children would themselves qualify for Medicaid and possibly for other federal programs. By CBO's estimates, in the one-year period in which federal funds for Planned Parenthood would be prohibited under the legislation, the number of births in the Medicaid program would increase by several thousand, increasing direct spending for Medicaid by \$21 million in 2017 and by \$77 million over the 2017–2026 period. Overall, with those costs netted against the savings estimated above, implementing the provision would reduce direct spending by \$156 million over the 2017–2026 period, CBO estimates.

Repeal of Medicaid Provisions. Under current law, states can elect the Community First Choice option, allowing them to receive a 6 percentage-point increase in their federal matching rate for some services provided by home and community-based attendants to certain Medicaid recipients. The legislation would terminate the increase in the federal matching funds beginning in calendar year 2020, which would decrease direct spending by about \$12 billion over the next 10 years.

Repeal of Reductions to Allotments for Disproportionate Share Hospitals. Under current law, Medicaid allotments to states for payments to hospitals that treat a disproportionate share of uninsured and Medicaid patients are to be cut significantly in each year from 2018 to 2025. The cuts are currently scheduled to be \$2 billion in 2018 and to increase each year until they reach \$8 billion in 2024 and 2025. The legislation would eliminate those cuts for states that have not expanded Medicaid under the ACA starting in 2018 and for the remaining states starting in 2020, boosting outlays by \$31 billion over the next 10 years.

Safety Net Funding for States That Did Not Expand Medicaid. The legislation would provide \$2 billion in funding in each year from 2018 to 2021 to states that did not expand Medicaid eligibility under the ACA. Those states could use the funding, within limits, to supplement payments to providers that treat Medicaid enrollees. Such payments to providers would not be subject to the per capita caps also established by the proposed legislation. Any states that chose to expand Medicaid coverage as of July 1 of each year from 2017 through 2020 would lose access to the funding available under this provision in the following year and thereafter. CBO estimates that this provision would increase direct spending by \$8 billion over the 2017–2026 period.

Reductions to States' Medicaid Costs. The legislation would make a number of additional changes to the Medicaid program, including these:

- Requiring states to treat lottery winnings and certain other income as income for purposes of determining eligibility;
- Decreasing the period when Medicaid benefits may be covered retroactively from up to three months before a recipient's application to the first of the month in which a recipient makes an application;

- Eliminating federal payments to states for Medicaid services provided to applicants who did not provide satisfactory evidence of citizenship or nationality during a reasonable opportunity period; and
- Eliminating states' option to increase the amount of allowable home equity from \$500,000 to \$750,000 for individuals applying for Medicaid coverage of long-term services and supports.

Together, CBO estimates, those changes would decrease direct spending by about \$7 billion over the 2017–2026 period.

Changes in Spending Subject to Appropriation

CBO has not completed an estimate of the potential impact of the legislation on discretionary spending, which would be subject to future appropriation action.

UNCERTAINTY SURROUNDING THE ESTIMATES

CBO and JCT considered the potential responses of many parties that would be affected by the legislation, including these:

- Federal agencies—which would need to implement major changes in the regulation of the health care system and administration of new subsidy structures and eligibility verification systems in a short time frame;
- States—which would need to decide how to use Patient and State Stability Fund grants, whether to pass new laws affecting the nongroup market, how to respond to the reduction in the federal matching rate for certain Medicaid enrollees, how to respond to constraints from the cap on Medicaid payments, and how to provide information to the federal government about insurers and enrollees;
- Insurers—who would need to decide about the extent of their participation in the insurance market and what types of plans to sell in the face of different market rules and federal subsidies;
- Employers—who would need to decide whether to offer insurance given the different federal subsidies and insurance products available to their employees;
- Individuals—who would make decisions about health insurance in the context of different premiums, subsidies, and penalties than those under current law; and
- Doctors and hospitals—who would need to negotiate contracts with insurers in a new regulatory environment.

Each of those responses is difficult to predict. Moreover, the responses would depend upon how the provisions in the legislation were implemented, such as whether advance payments of the new tax credits were made reliably. And flaws in the determination of eligibility, for instance, could keep subsidies from people who were eligible or provide them to people who were not.

In addition, CBO and JCT's projections under current law itself are inexact, which could also affect the estimated effects. For example, enrollment in the marketplaces under current law could be

lower than is projected, which would tend to decrease the budgetary savings of the legislation. Alternatively, the average subsidy per enrollee under current law could be higher than is projected, which would tend to increase the budgetary savings of the legislation.

CBO and JCT have endeavored to develop estimates that are in the middle of the distribution of potential outcomes. One way to assess the range of uncertainty around the estimated effects of the legislation is to compare previous projections with actual results. For example, some aspects of CBO and JCT's projections of health insurance coverage and related spending made in July 2012 (after the Supreme Court issued a decision that essentially made the expansion of the Medicaid program under the ACA an option for states) can be compared with actual results for 2016. Projected spending on people made eligible for Medicaid because of the ACA was about 60 percent of the actual amount. The number of people predicted in 2012 to purchase insurance through the marketplaces in 2016 was more than twice the actual number. The decline in the number of insured people from 2012 to 2016 was projected to be 23 million, and the decline measured in the National Health Interview Survey turned out to be 20 million. CBO and JCT have continued to learn from experience with the ACA and have endeavored to use that experience to improve their modeling.

That comparison of projections with actual results and the great uncertainties surrounding the actions of the many parties that would be affected by the legislation suggest that outcomes of the legislation could differ substantially from some of the estimates provided here. Nevertheless, CBO and JCT are confident about the direction of certain effects of the legislation. For example, spending on Medicaid would almost surely be lower than under current law. The cost of the new tax credit would probably be lower than the cost of the subsidies for coverage through marketplaces under current law. And the number of uninsured people under the legislation would almost surely be greater than under current law.

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than \$5 billion in any of the four consecutive 10-year periods beginning in 2027.

MANDATES ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

JCT and CBO reviewed the provisions of the legislation and determined that they would impose no intergovernmental mandates as defined in the Unfunded Mandates Reform Act. For large entitlement programs like Medicaid, UMRA defines an increase in the stringency of conditions or a cap on federal funding as an intergovernmental mandate if the affected governments lack authority to offset those costs while continuing to provide required services. As discussed earlier in this estimate, the legislation would eliminate the enhanced federal matching rate for some future enrollees, establish new per capita caps in the Medicaid program, and make

other changes that would affect Medicaid spending—some of which would provide additional assistance to states.

On net, CBO estimates that states would see an overall decrease in federal assistance, as reflected in estimates of federal savings in the Medicaid program. In response to the caps and other changes, CBO anticipates that states could use existing flexibility allowed in the Medicaid program and additional authorities provided by the legislation to cut payments to health care providers and health plans, eliminate optional services, restrict eligibility for enrollment, or (to the extent feasible) change the way services are delivered to save costs. Because flexibility in the program would allow states to make such changes and still provide statutorily required services, the per capita caps and other changes in Medicaid would not impose intergovernmental mandates as defined in UMRA.

MANDATES ON THE PRIVATE SECTOR

JCT and CBO have determined that the legislation would impose private-sector mandates as defined in UMRA. On the basis of information from JCT, CBO estimates that the aggregate direct cost of the mandates imposed by the legislation would exceed the annual threshold established in UMRA for private-sector mandates (\$156 million in 2017, adjusted annually for inflation).

The tax provisions of the legislation contain two mandates. Specifically, the legislation would recapture excess advance payments of premium tax credits (so that the full amount of excess advance payments is treated as an additional tax liability for the individual) and repeal the small business (health insurance) tax credit.

The nontax provisions of the legislation would impose a private-sector mandate as defined in UMRA on insurers that offer health insurance coverage in the individual or small-group market. The legislation would require those insurers to charge a penalty equal to 30 percent of the monthly premium for a period of 12 months to individuals who enroll in insurance in a given year after having allowed their health insurance to lapse for more than 63 days during the previous year. CBO estimates that the costs of complying with the mandate would be largely offset by the penalties insurers would collect.

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TABLE 1.—SUMMARY OF THE DIRECT SPENDING AND REVENUE EFFECTS OF THE AHCA, THE BUDGET RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEES ON WAYS AND MEANS AND ENERGY AND COMMERCE, MARCH 9, 2017

	[Billions of dollars, by fiscal year]										
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
CHANGES IN DIRECT SPENDING^a											
Coverage Provisions:											
Estimated Budget Authority	–6.6	–12.5	–22.9	–97.6	–139.1	–157.4	–173.8	–186.9	–199.4	–210.5	–278.6
Estimated Outlays	–6.6	–27.5	–25.6	–92.5	–138.6	–158.5	–175.2	–188.5	–201.3	–212.0	–290.7
Non Coverage Provisions:											
Estimated Budget Authority	0.3	–0.5	–0.7	0.6	1.7	–0.2	1.0	1.1	0.7	0.0	1.3
Estimated Outlays	–0.1	0.3	–0.1	0.8	1.8	0.5	0.8	1.5	1.3	0.3	2.7
Total Changes in Direct Spending:											
Estimated Budget Authority	–6.3	–13.0	–23.6	–97.1	–137.4	–157.6	–172.8	–185.8	–198.7	–210.5	–277.4
Estimated Outlays	–6.7	–27.2	–25.7	–91.7	–136.9	–158.0	–174.3	–187.0	–200.0	–211.7	–288.1
CHANGES IN REVENUES^b											
Coverage Provisions	–3.8	–13.7	–16.8	–25.5	–33.6	–36.4	–38.9	–40.4	–41.0	–40.7	–290.9
Non Coverage Provisions	–2.1	–37.5	–41.8	–57.6	–65.1	–70.2	–76.0	–83.1	–79.7	–78.7	–591.9
Total Changes in Revenues	–5.9	–51.2	–58.6	–83.1	–98.7	–106.6	–114.9	–123.5	–120.6	–119.4	–882.8
INCREASE OR DECREASE (–) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING OR REVENUES											
Net Increase or Decrease (–) in the Deficit	–0.8	24.0	33.0	–8.6	–38.2	–51.3	–59.4	–63.5	–79.4	–92.4	9.4

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: The costs of this legislation fall within budget function 550 (health), 570 (Medicare), 600 (Income Security), and 650 (Social Security).

AHCA = American Health Care Act; numbers may not add up to totals because of rounding.

^a For outlays, a positive number indicates an increase (adding to the deficit) and a negative number indicates a decrease (reducing the deficit).

^b For revenues, a positive number indicates an increase (adding to the deficit) and a negative number indicates a decrease (reducing the deficit).

TABLE 2.—ESTIMATE OF THE DIRECT SPENDING AND REVENUE EFFECTS OF THE AHCA, THE BUDGET RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEES ON WAYS AND MEANS AND ENERGY AND COMMERCE, MARCH 9, 2017

	[Billions of dollars, by fiscal year]										
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
CHANGES IN DIRECT SPENDING^a											
Coverage Provisions:											
Estimated Budget Authority	–6.6	–12.5	–22.9	–97.6	–139.1	–157.4	–173.8	–186.9	–199.4	–210.5	–278.6
Estimated Budget Authority	–6.6	–12.5	–22.9	–97.6	–139.1	–157.4	–173.8	–186.9	–199.4	–210.5	–278.6

TABLE 2.—ESTIMATE OF THE DIRECT SPENDING AND REVENUE EFFECTS OF THE AHCA, THE BUDGET RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEES ON WAYS AND MEANS AND ENERGY AND COMMERCE, MARCH 9, 2017—Continued

[Billions of dollars, by fiscal year]

[illegible]

[illegible]

TABLE 2.—ESTIMATE OF THE DIRECT SPENDING AND REVENUE EFFECTS OF THE AHCA, THE BUDGET RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEES ON WAYS AND MEANS AND ENERGY AND COMMERCE, MARCH 9, 2017—Continued

(Billions of dollars, by fiscal year)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2021	2017–2026
On-Budget	–4.5	–17.0	–19.9	–27.6	–35.5	–38.4	–41.7	–44.7	–46.7	–48.0	–104.5	–324.2
Off-Budget	0.7	3.3	3.1	2.0	1.9	2.0	2.8	4.3	5.8	7.3	11.1	33.3
Recapture Excess Advance Payments of Premium Tax Credits	0	0.6	0.7	0.5	0	0	0	0	0	0	1.8	1.8
Additional Modifications to Premium Tax Credit					[Included in estimate of coverage provisions]							
Premium Tax Credit					[Included in estimate of coverage provisions]							
Small Business Tax Credit					[Included in estimate of coverage provisions]							
Individual Mandate					[Included in estimate of coverage provisions]							
Employer Mandate					[Included in estimate of coverage provisions]							
Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits ^d	0	0	0	–3.4	–6.9	–8.7	–10.7	–13.6	–5.5	0	–10.3	–48.7
Repeal of Tax on Over-the-Counter Medications	0	–0.4	–0.5	–0.6	–0.6	–0.6	–0.6	–0.7	–0.7	–0.7	–2.1	–5.5
Repeal of Increase of Tax on Health Savings	0	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	–0.1
Repeal of Limitations on Contributions to Flexible Spending Accounts	0	–0.3	–1.2	–1.6	–1.7	–1.8	–2.2	–2.6	–3.3	–4.1	–4.7	–18.6
Repeal of Tax on Prescription Medications	0	–3.1	–2.7	–2.7	–2.7	–2.7	–2.7	–2.7	–2.7	–2.7	–11.2	–24.8
Repeal of Medical Device Excise Tax	0	–1.4	–1.9	–2.0	–2.1	–2.2	–2.3	–2.4	–2.6	–2.7	–7.4	–19.6
Repeal of Health Insurance Tax	0	–12.8	–13.5	–14.3	–15.1	–15.9	–16.8	–17.8	–18.7	–19.7	–55.7	–144.7
Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy	0	–0.1	–0.2	–0.2	–0.2	–0.2	–0.2	–0.2	–0.2	–0.2	–0.6	–1.7
Repeal of Increase in Income Threshold for Determining Medical Care Deduction	–0.2	–2.0	–3.2	–3.4	–3.6	–3.9	–4.2	–4.5	–4.8	–5.1	–12.4	–34.9
Repeal of Medicare Tax Increase	–0.4	–6.5	–10.1	–11.4	–12.3	–13.2	–14.1	–15.2	–16.5	–17.6	–40.8	–117.3
Refundable Tax Credit for Health Insurance					[Included in estimate of coverage provisions]							
Maximum Contribution Limit to Health Savings	0	–1.0	–1.6	–1.7	–1.9	–2.1	–2.3	–2.5	–2.7	–2.9	–6.2	–18.6
Allow Both Spouses to Make Catch-up Contributions to the Same Health Savings Account	0	(*)	(*)	(*)	(*)	(*)	(*)	(*)	–0.1	–0.1	–0.1	–0.4
Special Rule for Certain Medical Expenses Incurred Before Establishment of Health Savings	0	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	–0.1	–0.2
Repeal of Tanning Tax	0	(*)	–0.1	–0.1	–0.1	–0.1	–0.1	–0.1	–0.1	–0.1	–0.2	–0.6
Repeal of Net Investment Tax	–1.5	–10.5	–7.5	–16.7	–17.8	–18.7	–19.7	–20.7	–21.7	–22.7	–54.1	–157.6
Remuneration	0	(*)	(*)	(*)	–0.1	–0.1	–0.1	–0.1	–0.1	–0.1	–0.1	–0.4
Total Changes in Revenues	–5.9	–51.2	–58.6	–83.1	–98.7	–106.6	–114.9	–123.5	–120.6	–119.4	–297.6	–882.8
On-Budget	–6.6	–53.8	–60.8	–83.3	–98.0	–105.5	–114.0	–123.2	–123.3	–124.7	–302.7	–893.5
Off-Budget	0.7	2.6	2.2	0.2	–0.7	–1.2	–1.0	–0.3	2.7	5.3	5.0	10.7
INCREASE OR DECREASE (–) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING OR REVENUES												
Net Increase or Decrease (–) in the Deficit	–0.8	24.0	33.0	–8.6	–38.2	–51.3	–59.4	–63.5	–79.4	–92.4	9.4	–336.5
On-Budget	(*)	26.6	35.1	–8.4	–38.8	–52.3	–59.9	–63.2	–76.0	–86.4	14.5	–323.3

Off-Budget -0.7 -2.6 -2.2 -0.2 0.6 0.9 0.5 -0.3 -3.3 -5.9 -5.1 -13.2

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: The costs of this legislation fall within budget function 550 (health), 570 (Medicare), 600 (Income Security), and 650 (Social Security).

Numbers may not add up to totals because of rounding; DSH = Disproportionate Share Hospital; AHCA = American Health Care Act;

* = an increase or decrease between zero and \$50 million.

^a For outlays, a positive number indicates an increase (adding to the deficit) and a negative number indicates a decrease (reducing the deficit).

^b Estimate interacts with the provision related to the Per Capita Allotment for Medical Assistance.

^c For revenues, a positive number indicates an increase (reducing the deficit) and a negative number indicates a decrease (adding to the deficit).

^d This estimate does not include effects of interactions with other subsidies; those effects are included in estimates of other relevant provisions.

TABLE 3.—NET BUDGETARY EFFECTS OF THE INSURANCE COVERAGE PROVISIONS OF THE AHCA

(Billions of dollars, by fiscal year)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total 2017–2026
Medicaid Outlays	-3	-18	-26	-68	-94	-111	-124	-135	-146	-155	-880
Subsidies for Coverage Through Marketplaces and Related Spending and Revenues ^{a,b} ..	-5	-11	-16	-62	-87	-91	-95	-99	-102	-106	-673
Small-Employer Tax Credits ^{b,c}	(*)	(*)	(*)	(*)	-1	-1	-1	-1	-1	-1	-6
Tax Credits for Nongroup Insurance ^{b,d}	0	0	0	30	44	47	52	58	63	68	361
Penalty Payments by Employers ^e	2	16	20	15	16	18	19	20	22	23	171
Penalty Payments by Uninsured People	3	3	3	3	4	4	4	4	4	5	38
Patient and State Stability Fund Grants	0	0	0	12	15	9	9	8	8	8	80
Medicare ^e	0	1	3	4	6	6	6	6	6	6	43
Other Effects on Revenues and Outlays ^{d,f}	-1	-5	-5	-4	-4	-4	-6	-10	-14	-18	-70
Total Effect on the Deficit	-3	-14	-9	-67	-105	-122	-136	-148	-160	-171	-935
Memorandum:											
Decreases in Mandatory Spending	-7	-27	-26	-93	-139	-158	-175	-188	-201	-212	-1,226
Decreases in Revenues	-4	-14	-17	-26	-34	-36	-39	-40	-41	-41	-291

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Except in the memorandum lines, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

Numbers may not add up to totals because of rounding; AHCA = American Health Care Act; * = between -\$500 million and zero.

^a Related spending and revenues include spending for the Basic Health Program and net spending and revenues for risk adjustment.

^b Includes effects on outlays and on revenues.

^c Effects on the deficit include the associated effects of changes in taxable compensation on revenues.

^d Includes costs for a new tax credit for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

^e Effects arise mostly from changes in Disproportionate Share Hospital payments.

^f Consists mainly of the effects of changes in taxable compensation on revenues. CBO also estimates that outlays for Social Security benefits would decrease by about \$3 billion over the 2017–2026 period.

TABLE 4.—ILLUSTRATIVE EXAMPLE OF SUBSIDIES FOR NONGROUP HEALTH INSURANCE
UNDER CURRENT LAW AND THE AHCA, 2026

[Dollars]

	Premium ^a	Premium tax credit ^b	Net premium paid	Actuarial value of plan after cost-sharing subsidies (percent) ^c
SINGLE INDIVIDUAL WITH ANNUAL INCOME OF \$26,500 (175 PERCENT OF FPL) ^d				
Current Law:				
21 years old	5,100	3,400	1,700	87
40 years old	6,500	4,800	1,700	
64 years old	15,300	13,600	1,700	
AHCA:				
21 years old	3,900	2,450	1,450	65
40 years old	6,050	3,650	2,400	
64 years old	19,500	4,900	14,600	
SINGLE INDIVIDUAL WITH ANNUAL INCOME OF \$68,200 (450 PERCENT OF FPL) ^d				
Current Law:				
21 years old	5,100	0	5,100	70
40 years old	6,500	0	6,500	
64 years old	15,300	0	15,300	
AHCA:				
21 years old	3,900	2,450	1,450	65
40 years old	6,050	3,650	2,400	
64 years old	19,500	4,900	14,600	

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

All dollar figures have been rounded to the nearest \$50; AHCA = American Health Care Act; FPL = federal poverty level.

^a For this illustration, CBO projected the average national premiums for a 21-year-old in the nongroup health insurance market in 2026 both under current law and under the AHCA. On the basis of those amounts, CBO calculated premiums for a 40-year-old and a 64-year-old, assuming that the person lives in a state that uses the federal default age-rating methodology, which limits variation of premiums to a ratio of 3 to 1 for adults under current law and 5 to 1 for adults under the AHCA. CBO projects that, under current law, most states will use the default 3-to-1 age-rating curve; under the AHCA, CBO projects, most would use an age-rating curve with a maximum ratio of 5 to 1.

^b Under current law, premium tax credits are calculated as the difference between the reference premium and a specified percentage of income for a person with income at a given percentage of the FPL. The reference premium is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which the person resides. A silver plan covers about 70 percent of the costs of covered benefits. CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026 for someone with income at 175 percent of the FPL takes into account the probability, estimated in CBO's March 2016 baseline, that additional indexing may apply. Under the AHCA, the premium tax credits offered for nongroup coverage would be indexed to the consumer price index for all urban consumers plus 1 percentage point. In 2026, CBO projects, those tax credits would be about 22 percent higher than the amounts specified in 2020.

^c The actuarial value of a plan is the percentage of costs for covered services that the plan pays. Cost-sharing subsidies are payments made by the federal government to insurers that reduce the cost-sharing amounts (out-of-pocket payments required under insurance policies) for covered people whose income is generally between 100 percent and 250 percent of the FPL. The cost-sharing subsidy amounts in this example would range from \$1,100 for a 21-year-old with income at 175 percent of the FPL to \$3,350 for a 64-year-old at the same income level. Under current law, cost-sharing subsidies have the effect of increasing the actuarial value of the plan from 70 percent for a typical silver plan to 94 percent for people whose income is between 100 percent and 149 percent of the FPL; 87 percent for people between 150 percent and 199 percent of the FPL; and 73 percent for people between 200 percent and 249 percent of the FPL. People whose income is 250 percent of the FPL or more would receive a standard 70 percent actuarial value when purchasing a silver plan. CBO projects that, under the AHCA, the elimination of required actuarial values and the structure of new tax credits would, by 2026, result in a reduction to about 65 percent in the average actuarial value of plans purchased in the nongroup market.

^d Income levels reflect modified adjusted gross income, which equals adjusted gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and income of dependent filers. CBO projects that in 2026, a modified adjusted gross income of \$26,500 would equal 175 percent of the FPL and an income of \$68,200 would equal 450 percent of the FPL.

TABLE 5.—EFFECTS OF THE AHCA ON HEALTH INSURANCE COVERAGE
FOR PEOPLE UNDER AGE 65

[Millions of people, by calendar year]

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Population Under Age 65	273	274	275	276	276	277	278	279	279	280
Uninsured Under Current Law	26	26	27	27	27	27	27	28	28	28
Change in Coverage Under the AHCA:										
Medicaid ^a	-1	-5	-6	-9	-12	-13	-13	-14	-14	-14
Nongroup coverage, including marketplaces ^b	-2	-6	-7	-9	-8	-8	-6	-5	-4	-2
Employment-based coverage	-1	-2	-2	-2	-2	-2	-3	-5	-5	-7
Other coverage ^c	(*)	(*)	(*)	-1	-1	-1	-1	-1	-1	-1
Uninsured	4	14	16	21	23	23	23	24	24	24
Uninsured Under the AHCA	31	41	43	48	50	50	51	51	51	52

TABLE 5.—EFFECTS OF THE AHCA ON HEALTH INSURANCE COVERAGE
FOR PEOPLE UNDER AGE 65—Continued

[Millions of people, by calendar year]

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Percentage of the Population Under Age 65 With Insurance Under the AHCA:										
Including all U.S. residents	89	85	84	83	82	82	82	82	82	81
Excluding unauthorized immigrants	91	87	87	85	84	84	84	84	84	84

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. They reflect average enrollment over the course of a year among noninstitutionalized civilian residents of the 50 states and the District of Columbia who are under the age of 65, and they include spouses and dependents covered under family policies.

AHCA = American Health Care Act; * = a reduction that falls between zero and 500,000 people.

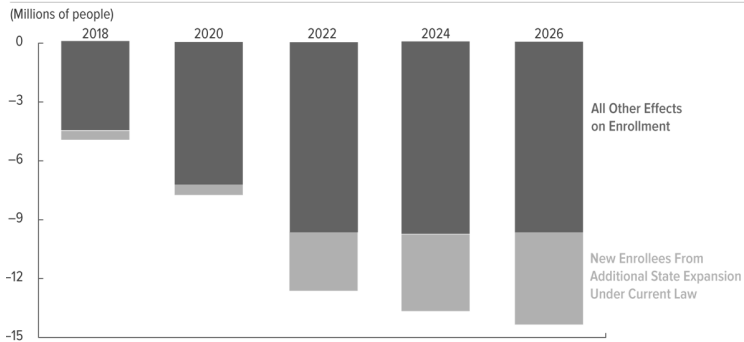
^a Includes noninstitutionalized enrollees with full Medicaid benefits.

^b Under current law, many people can purchase subsidized health insurance coverage through the marketplaces (sometimes called exchanges) operated by the federal government, by state governments, or as partnerships between federal and state governments. People also can purchase unsubsidized coverage in the nongroup market outside of those marketplaces. Under the AHCA, people could receive subsidies for coverage purchased either inside or outside of the marketplaces.

^c Includes coverage under the Basic Health Program, which allows states to establish a coverage program primarily for people whose income is between 138 percent and 200 percent of the federal poverty level. To subsidize that coverage, the federal government provides states with funding that is equal to 95 percent of the subsidies for which those people would otherwise have been eligible by purchasing health insurance through a marketplace. Payments for that program would be rescinded by the AHCA in 2020.

Figure 1.

Changes in Medicaid Enrollment Under the AHCA, Selected Years

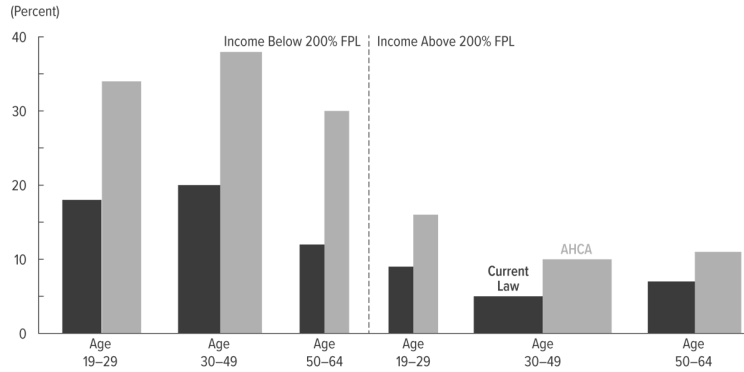


Source: Congressional Budget Office.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. They reflect average enrollment over the course of a year. Under CBO's current-law projections, additional states would expand Medicaid eligibility to people who are made newly eligible under the Affordable Care Act (adults under the age of 65 whose income is below 138 percent of the federal poverty level). Enrollment estimates associated with those future expansions are separated in the figure to highlight the change in Medicaid enrollment under the AHCA because CBO anticipates that states that would expand coverage in the future under current law would not do so under the AHCA.

AHCA = American Health Care Act.

Figure 2.

Share of Nonelderly Adults Without Health Insurance Coverage Under Current Law and Under the AHCA, by Age and Income Level, 2026


Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. They reflect the average number of people without insurance coverage over the course of the year in the noninstitutionalized civilian population of the 50 states and the District of Columbia.

The width of each bar represents the relative share of the population in each age and income category. In CBO's projections, 200 percent of the FPL in 2026 would amount to \$30,300 for a single person.

AHCA = American Health Care Act; FPL = federal poverty level.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

Pursuant to clause 3(c)(4) of rule XIII, the general performance goal or objective of this legislation is to advance the repeal and replacement of PPACA and begin the process of lowering health care costs, increasing plan options for consumers, and helping to ensure the Medicaid health care safety is put on sustainable footing.

DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII, no provision of the Committee Print is known to be duplicative of another Federal program, including any program that was included in a report to Congress pursuant to section 21 of Public Law 111–139 or the most recent Catalog of Federal Domestic Assistance.

COMMITTEE COST ESTIMATE

Pursuant to clause 3(d)(1) of rule XIII, the Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

EARMARK, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

Pursuant to clause 9(e), 9(f), and 9(g) of rule XXI, the Committee finds that the Committee Print contains no earmarks, limited tax benefits, or limited tariff benefits.

DISCLOSURE OF DIRECTED RULE MAKINGS

Pursuant to section 3(i) of H. Res. 5, the Committee finds that the Committee Print contains no directed rule makings.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Subtitle A—Patient Access to Public Health Programs

Section 101. The Prevention and Public Health Fund: This section repeals Section 4002 of the Patient Protection and Affordable Care Act. Section 4002 established the Prevention and Public Health Fund (PPHF) as a permanent advanced appropriation for

prevention, wellness, and public health initiatives to be administered Department of Health and Human Services (HHS). This section repeals PPHF appropriations for fiscal year (FY) 2019 onwards and rescinds unobligated funds at the end of FY 2018.

Section 102. Community Health Center Program: This section provides increased funding for the Community Health Center Fund, which awards grants to Federally Qualified Health Centers (FQHCs).

Section 103. Federal Payments to States: This section imposes a one-year freeze on mandatory funding to a class of providers designated as prohibited entities. A prohibited entity is one that meets the following criteria: it is designated as a non-profit by the Internal Revenue Service; it is an essential community provider primarily engaged in family planning and reproductive health services; it provides abortions in cases that do not meet the Hyde amendment exception for federal payment; and it received over \$350 million in federal and state Medicaid dollars in fiscal year 2014.

Subtitle B—Medicaid Program Enhancement

Section 111. Repeal of Medicaid Provisions: This section repeals States' expanded authority to make presumptive eligibility determinations for certain populations and alter mandatory Medicaid income eligibility level for poverty-related children back to 100 percent of federal poverty level. In addition, this section repeals the 6-percentage point bonus in the federal match rate for community-based attendant services.

Section 112. Repeal of Medicaid Expansion: This section codifies NFIB v. Sebelius by making Medicaid expansion optional for States. This section also repeals the State option to extend coverage to adults above 133 percent of federal poverty by December 31, 2019, and ends the enhanced match rate for newly eligible beneficiaries after December 31, 2019. States can keep the enhanced match for *newly eligible* expenditures that occur before January 1, 2020. However, for expenditures after January 1, 2020, the *newly eligible* matching rate would only apply to expenditures for newly eligible individuals who were enrolled in Medicaid (under the State plan or a waiver) as of December 31, 2019 and do not have a break in eligibility for more than one month after that date. After January 1, 2020, the State could only enroll newly eligible individuals at the State's traditional FMAP for that individual. This section also amends the formula for the expansion State matching rate so that the matching rate stops phasing up after calendar year (CY) 2017 and the transition percentage would remain at the CY 2017 level for each subsequent year. In addition, for expenditures after January 1, 2020, the *expansion State* matching rate would only apply to expenditures for individuals who are eligible for the expansion State matching rate and were enrolled in Medicaid (under the State plan or a waiver) as of December 31, 2019, and do not have a break in eligibility for more than one month after that date. After January 1, 2020, the State would have the option to enroll newly eligible individuals, but the State would receive the State's traditional federal medical assistance program (FMAP) for that individual.

The section also repeals the requirement that State Medicaid plans must provide the same “essential health benefits” that are required by plans on the exchanges, returning flexibility to the States on December 31, 2019.

Section 113. Elimination of DSH Cuts: This section repeals the Medicaid Disproportionate Share Hospital (DSH) cuts for non-expansion States in 2018. States that expanded Medicaid would have their DSH cuts repealed in 2020.

Section 114. Reducing State Medicaid Costs: This section would eliminate an unintended consequence in the current statute and regulations by requiring States, for purposes of determining modified adjusted gross income (MAGI) for Medicaid and CHIP eligibility, to consider monetary winnings from lotteries (and other lump sum payments) as if they were obtained over multiple months, even if obtained in a single month.

This section would close the loophole by requiring individuals to provide documentation of citizenship or lawful presence before obtaining coverage.

This section would repeal the authority for States to elect to substitute a higher home equity limit that is above the statutory minimum in law. It would apply to Medicaid eligibility determinations that are made more than 180 days after enactment. In situations where the Secretary of HHS determines that State legislation would be required to amend the State plan, then States would have additional time to comply with these requirements.

Section 115. Safety Net Funding for Non-Expansion States: This section provides \$10 billion over five years to non-expansion States for safety net funding for CY 2018 through CY 2022.

Section 116. Providing Incentives for Increased Frequency of Eligibility Redetermination: This section requires States with Medicaid expansion populations to re-determine expansion enrollees’ eligibility every 6 months. This policy also provides a temporary five percent FMAP increase to States for activities directly related to complying with this section.

Subtitle C—Per Capita Allotment for Medical Assistance

Section 121. Per Capita Allotment for Medical Assistance: Reforms federal Medicaid financing by creating a per capita cap model (i.e., per enrollee limits on federal payments to States) starting in FY 2020. Section 121 would use each State’s spending in FY 2016 as the base year to set targeted spending for each enrollee category (elderly, blind and disabled, children, non-expansion adults, and expansion adults) in FY 2019 and subsequent years for that State. Each State’s targeted spending amount would increase by the percentage increase in the medical care component of the consumer price index for all urban consumers from September 2019 to September of the next fiscal year. Starting in FY 2020, any State with spending higher than their specified targeted aggregate amount would receive reductions to their Medicaid funding for the following fiscal year.

Section 121 would also modernize Medicaid’s data and reporting systems. The additional reporting requirements would include data on medical assistance expenditures within categories of services and categories of all enrollees on Medicaid.

Certain payments are exempt from the caps. For example, DSH payments operate outside of the caps since they are already a capped allotment. Administrative payments are also exempt. In addition, certain populations would be exempt.

Finally, to ensure that gaming does not take place, the Secretary of Health and Human Services (HHS) would conduct audits of each State's enrollment and expenditures reported on the Form CMS-64 for FY 2016, FY 2019, and subsequent years.

Subtitle D—Patient Relief and Health Insurance Market Stability

Section 131. Repeal of Cost-Sharing Subsidy: This section repeals the Affordable Care Act (ACA) cost-sharing subsidy program at the end of 2019. The Obama administration made payments through this program without an appropriation, leading to a lawsuit from House Republicans arguing that Congress and in particular, the House of Representatives alone holds the constitutional power of the purse. The lawsuit is being held in abeyance. The next filing date in the case for both parties is May 22, 2017.

Section 132. Patient and State Stability Fund: This section establishes the Patient and State Stability Fund, which is designed to lower patient costs and stabilize State markets.

If a State chooses not to use the funding for their own program, the resources will be available to the Administrator of CMS to help stabilize premiums for patients.

This section annually appropriates \$15 billion for State use for 2018 and 2019. For years 2020 through 2026, \$10 billion is appropriated annually. A State match is phased in beginning in 2020 at a different schedule, depending if a State chooses to use the money for their own program or utilizes the federal default program administered through CMS.

Section 133. Continuous Health Insurance Coverage Incentive: The continuous coverage incentive would limit adverse selection in health care markets. Beginning in open enrollment for benefit year 2019, there will be a 12-month lookback period to determine if the applicant went longer than 63 days without continuous health insurance coverage. If the applicant had a lapse in coverage for greater than 63 days, issuers will assess a flat 30 percent late-enrollment surcharge on top of their base premium based on their decision to forgo coverage. This late-enrollment surcharge would be the same for all market entrants, regardless of health status, and discontinued after 12 months, incentivizing enrollees to remain covered. This process would begin for special enrollment period applicants in benefit year 2018.

Section 134. Increasing Coverage Options: Under the ACA, plan issuers are required to label their offerings by metal tier: Bronze, Silver, Gold, and Platinum. These metal tiers are determined by a calculation known as actuarial value (AV). This section repeals the AV standards.

Section 135. Change in Permissible Age Variation in Health Insurance Premium Rate: Current law limits the cost of the most generous plan for older Americans to three times the cost of the least generous plan for younger Americans. The true cost of care is 4.8-to-one, according to health economists. This provision

loosens the ratio to five-to-one and gives States the flexibility to set their own ratio.

CHANGES IN EXISTING LAW MADE BY TITLE I OF FY2017 BUDGET
RECONCILIATION, AS RECOMMENDED BY THE COMMITTEE ON EN-
ERGY AND COMMERCE

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

PATIENT PROTECTION AND AFFORDABLE CARE ACT

* * * * *

**TITLE I—QUALITY, AFFORDABLE
HEALTH CARE FOR ALL AMERICANS**

* * * * *

**Subtitle D—Available Coverage Choices for
All Americans**

**PART 1—ESTABLISHMENT OF QUALIFIED
HEALTH PLANS**

* * * * *

SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

(a) **ESSENTIAL HEALTH BENEFITS PACKAGE.**—In this title, the term “essential health benefits package” means, with respect to any health plan, coverage that—

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e) *and with respect to a plan year before plan year 2020*, provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) **ESSENTIAL HEALTH BENEFITS.**—

(1) **IN GENERAL.**—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

- (A) Ambulatory patient services.
- (B) Emergency services.
- (C) Hospitalization.

- (D) Maternity and newborn care.
 - (E) Mental health and substance use disorder services, including behavioral health treatment.
 - (F) Prescription drugs.
 - (G) Rehabilitative and habilitative services and devices.
 - (H) Laboratory services.
 - (I) Preventive and wellness services and chronic disease management.
 - (J) Pediatric services, including oral and vision care.
- (2) LIMITATION.—
- (A) IN GENERAL.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.
- (B) CERTIFICATION.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).
- (3) NOTICE AND HEARING.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.
- (4) REQUIRED ELEMENTS FOR CONSIDERATION.—In defining the essential health benefits under paragraph (1), the Secretary shall—
- (A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;
 - (B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;
 - (C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;
 - (D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;
 - (E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) REQUIREMENTS RELATING TO COST-SHARING.—

(1) ANNUAL LIMITATION ON COST-SHARING.—

(A) 2014.—The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section

223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 AND LATER.—In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(2)

(3) COST-SHARING.—In this title—

(A) IN GENERAL.—The term “cost-sharing” includes—

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to essential health benefits covered under the plan.

(B) EXCEPTIONS.—Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(4) PREMIUM ADJUSTMENT PERCENTAGE.—For purposes of paragraph (1)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) LEVELS OF COVERAGE.—

(1) LEVELS OF COVERAGE DEFINED.—The levels of coverage described in this subsection are as follows:

(A) BRONZE LEVEL.—A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(B) SILVER LEVEL.—A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(C) GOLD LEVEL.—A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) PLATINUM LEVEL.—A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) ACTUARIAL VALUE.—

(A) IN GENERAL.—Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

(B) EMPLOYER CONTRIBUTIONS.—The Secretary shall issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer.

(C) APPLICATION.—In determining under this title, the Public Health Service Act, or the Internal Revenue Code of 1986 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

(3) ALLOWABLE VARIANCE.—The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

(4) PLAN REFERENCE.—In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

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

(e) CATASTROPHIC PLAN.—

(1) IN GENERAL.—A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if—

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides—

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in

effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(ii) coverage for at least three primary care visits.

(2) INDIVIDUALS ELIGIBLE FOR ENROLLMENT.—An individual is described in this paragraph for any plan year if the individual—

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of—

(i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

(3) RESTRICTION TO INDIVIDUAL MARKET.—If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) CHILD-ONLY PLANS.—If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

(g) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.—If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.

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Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST- SHARING REDUCTIONS

Subpart A—Premium Tax Credits and Cost- Sharing Reductions

* * * * *

[SEC. 1402. REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.

[(a) IN GENERAL.—In the case of an eligible insured enrolled in a qualified health plan—

[(1) the Secretary shall notify the issuer of the plan of such eligibility; and

[(2) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c).

[(b) ELIGIBLE INSURED.—In this section, the term “eligible insured” means an individual—

[(1) who enrolls in a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and

[(2) whose household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved.

In the case of an individual described in section 36B(c)(1)(B) of the Internal Revenue Code of 1986, the individual shall be treated as having household income equal to 100 percent for purposes of applying this section.

[(c) DETERMINATION OF REDUCTION IN COST-SHARING.—

[(1) REDUCTION IN OUT-OF-POCKET LIMIT.—

[(A) IN GENERAL.—The reduction in cost-sharing under this subsection shall first be achieved by reducing the applicable out-of-pocket limit under section 1302(c)(1) in the case of—

[(i) an eligible insured whose household income is more than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, by two-thirds;

[(ii) an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, by one-half; and

[(iii) an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, by one-third.

[(B) COORDINATION WITH ACTUARIAL VALUE LIMITS.—

[(i) IN GENERAL.—The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan’s share of the total allowed costs of benefits provided under the plan above—

[(I) 94 percent in the case of an eligible insured described in paragraph (2)(A);

[(II) 87 percent in the case of an eligible insured described in paragraph (2)(B);

[(III) 73 percent in the case of an eligible insured whose household income is more than 200 percent but not more than 250 percent of the poverty line for a family of the size involved; and

[(IV) 70 percent in the case of an eligible insured whose household income is more than 250 percent but not more than 400 percent of the poverty line for a family of the size involved.

[(ii) ADJUSTMENT.—The Secretary shall adjust the out-of-pocket limits under paragraph (1) if necessary to ensure that such limits do not cause the respective

actuarial values to exceed the levels specified in clause (i).

[(2) ADDITIONAL REDUCTION FOR LOWER INCOME INSURED.—The Secretary shall establish procedures under which the issuer of a qualified health plan to which this section applies shall further reduce cost-sharing under the plan in a manner sufficient to—

[(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 150 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 94 percent of such costs;

[(B) in the case of an eligible insured whose household income is more than 150 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 87 percent of such costs; and

[(C) in the case of an eligible insured whose household income is more than 200 percent but not more than 250 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 73 percent of such costs.

[(3) METHODS FOR REDUCING COST-SHARING.—

[(A) IN GENERAL.—An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions.

[(B) CAPITATED PAYMENTS.—The Secretary may establish a capitated payment system to carry out the payment of cost-sharing reductions under this section. Any such system shall take into account the value of the reductions and make appropriate risk adjustments to such payments.

[(4) ADDITIONAL BENEFITS.—If a qualified health plan under section 1302(b)(5) offers benefits in addition to the essential health benefits required to be provided by the plan, or a State requires a qualified health plan under section 1311(d)(3)(B) to cover benefits in addition to the essential health benefits required to be provided by the plan, the reductions in cost-sharing under this section shall not apply to such additional benefits.

[(5) SPECIAL RULE FOR PEDIATRIC DENTAL PLANS.—If an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) for any plan year, subsection (a) shall not apply to that portion of any reduction in cost-sharing under subsection (c) that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J).

[(d) SPECIAL RULES FOR INDIANS.—

[(1) INDIANS UNDER 300 PERCENT OF POVERTY.—If an individual enrolled in any qualified health plan in the individual

market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—

[(A) such individual shall be treated as an eligible insured; and

[(B) the issuer of the plan shall eliminate any cost-sharing under the plan.

[(2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.—If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

[(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and

[(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).

[(3) PAYMENT.—The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.

[(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

[(1) IN GENERAL.—If an individual who is an eligible insured is not lawfully present—

[(A) no cost-sharing reduction under this section shall apply with respect to the individual; and

[(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

[(i) A method under which—

[(I) the taxpayer's family size is determined by not taking such individuals into account, and

[(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

[(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

[(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

[(ii) A comparable method reaching the same result as the method under clause (i).

[(2) LAWFULLY PRESENT.—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the cost-sharing reduction under this

section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

[(3) SECRETARIAL AUTHORITY.—The Secretary, in consultation with the Secretary of the Treasury, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.]

[(f) DEFINITIONS AND SPECIAL RULES.—In this section:

[(1) IN GENERAL.—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.]

[(2) LIMITATIONS ON REDUCTION.—No cost-sharing reduction shall be allowed under this section with respect to coverage for any month unless the month is a coverage month with respect to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B of such Code.]

[(3) DATA USED FOR ELIGIBILITY.—Any determination under this section shall be made on the basis of the taxable year for which the advance determination is made under section 1412 and not the taxable year for which the credit under section 36B of such Code is allowed.]]

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TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems

* * * * *

SEC. 4002. PREVENTION AND PUBLIC HEALTH FUND.

(a) PURPOSE.—It is the purpose of this section to establish a Prevention and Public Health Fund (referred to in this section as the “Fund”), to be administered through the Department of Health and Human Services, Office of the Secretary, to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.

(b) FUNDING.—There are hereby authorized to be appropriated, and appropriated, to the Fund, out of any monies in the Treasury not otherwise appropriated—

(1) for fiscal year 2010, \$500,000,000;

(2) for each of fiscal years 2012 through 2017, \$1,000,000,000; and

(3) for [each of fiscal years 2018 and 2019] *fiscal year 2018*, \$900,000,000[;].

[(4) for each of fiscal years 2020 and 2021, \$1,000,000,000; and

[(5) for fiscal year 2022, \$1,500,000,000;

[(6) for fiscal year 2023, \$1,000,000,000;

[(7) for fiscal year 2024, \$1,700,000,000; and

[(8) for fiscal year 2025 and each fiscal year thereafter, \$2,000,000,000.]]

(c) **USE OF FUND.**—The Secretary shall transfer amounts in the Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal year 2008 level, for programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research, health screenings, and initiatives, such as the Community Transformation grant program, the Education and Outreach Campaign Regarding Preventive Benefits, and immunization programs.

(d) **TRANSFER AUTHORITY.**—The Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives may provide for the transfer of funds in the Fund to eligible activities under this section, subject to subsection (c).

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MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015

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TITLE II—MEDICARE AND OTHER HEALTH EXTENDERS

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Subtitle B—Other Health Extenders

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SEC. 221. EXTENSION OF FUNDING FOR COMMUNITY HEALTH CENTERS, THE NATIONAL HEALTH SERVICE CORPS, AND TEACHING HEALTH CENTERS.

(a) **FUNDING FOR COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS.**—

(1) **COMMUNITY HEALTH CENTERS.**—Section 10503(b)(1)(E) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b-2(b)(1)(E)) is amended by striking “for fiscal year 2015” and inserting “for each of fiscal years 2015 through 2017, *and an additional \$422,000,000 for fiscal year 2017*”.

(2) **NATIONAL HEALTH SERVICE CORPS.**—Section 10503(b)(2)(E) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b-2(b)(2)(E)) is amended by striking “for fiscal year 2015” and inserting “for each of fiscal years 2015 through 2017”.

(b) **EXTENSION OF TEACHING HEALTH CENTERS PROGRAM.**—Section 340H(g) of the Public Health Service Act (42 U.S.C. 256h(g))

is amended by inserting “and \$60,000,000 for each of fiscal years 2016 and 2017” before the period at the end.

(c) APPLICATION.—Amounts appropriated pursuant to this section for fiscal year 2016 and fiscal year 2017 are subject to the requirements contained in Public Law 113-235 for funds for programs authorized under sections 330 through 340 of the Public Health Service Act (42 U.S.C. 254b-256).

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SOCIAL SECURITY ACT

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TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

PART A—GENERAL PROVISIONS

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CIVIL MONETARY PENALTIES

SEC. 1128A. (a) Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5)) that—

(1) knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)), a claim (as defined in subsection (i)(2)) that the Secretary determines—

(A) is for a medical or other item or service that the person knows or should know was not provided as claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,

(B) is for a medical or other item or service and the person knows or should know the claim is false or fraudulent,

(C) is presented for a physician’s service (or an item or service incident to a physician’s service) by a person who knows or should know that the individual who furnished (or supervised the furnishing of) the service—

(i) was not licensed as a physician,

(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing), or

(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified,

(D) is for a medical or other item or service furnished during a period in which the person was excluded from the

program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1128, 1156, 1160(b) (as in effect on September 2, 1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987), or 1866(b) or as a result of the application of the provisions of section 1842(j)(2), or

(E) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary;

(2) knowingly presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1842(b)(3)(B)(ii), or (B) an agreement with a State agency (or other requirement of a State plan under title XIX) not to charge a person for an item or service in excess of the amount permitted to be charged, or (C) an agreement to be a participating physician or supplier under section 1842(h)(1), or (D) an agreement pursuant to section 1866(a)(1)(G);

(3) knowingly gives or causes to be given to any person, with respect to coverage under title XVIII of inpatient hospital services subject to the provisions of section 1886, information that he knows or should know is false or misleading, and that could reasonably be expected to influence the decision when to discharge such person or another individual from the hospital;

(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection—

(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

(B) is an officer or managing employee (as defined in section 1126(b)) of such an entity;

(5) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program (as so defined);

(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f)), for the provision of items or services for which payment may be made under such a program;

(7) commits an act described in paragraph (1) or (2) of section 1128B(b);

(8) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; or

(9) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;

(8) orders or prescribes a medical or other item or service during a period in which the person was excluded from a Federal health care program (as so defined), in the case where the person knows or should know that a claim for such medical or other item or service will be made under such a program;

(9) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program (as so defined), including Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;

(10) knows of an overpayment (as defined in paragraph (4) of section 1128J(d)) and does not report and return the overpayment in accordance with such section;

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$10,000 for each item or service [(or, in cases under paragraph (3))] *(or, in cases under paragraph (1) in which an individual was knowingly enrolled on or after October 1, 2017, pursuant to section 1902(a)(10)(A)(i)(VIII) for medical assistance under the State plan under title XIX whose income does not meet the income threshold specified in such section or in which a claim was presented on or after October 1, 2017, as a claim for an item or service furnished to an individual described in such section but whose enrollment under such State plan is not made on the basis of such individual's meeting the income threshold specified in such section, \$20,000 for each such individual or claim; in cases under paragraph (3), \$15,000 for each individual with respect to whom false or misleading information was given; in cases under paragraph (4), \$10,000 for each day the prohibited relationship occurs; in cases under paragraph (7), \$50,000 for each such act; or in cases under paragraph (9), \$50,000 for each false statement or misrepresentation of a material fact).* In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim (or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose; or in cases under

paragraph (9), an assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement or misrepresentation of a material fact). In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1128B(f)(1)) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

(b)(1) If a hospital or a critical access hospital knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit medically necessary services provided with respect to individuals who—

(A) are entitled to benefits under part A or part B of title XVIII or to medical assistance under a State plan approved under title XIX, and

(B) are under the direct care of the physician, the hospital or a critical access hospital shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$2,000 for each such individual with respect to whom the payment is made.

(2) Any physician who knowingly accepts receipt of a payment described in paragraph (1) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$2,000 for each individual described in such paragraph with respect to whom the payment is made.

(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

(i) \$5,000, or

(ii) three times the amount of the payments under title XVIII for home health services which are made pursuant to such certification.

(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII, that an individual meets the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home health services furnished to the individual.

(c)(1) The Secretary may initiate a proceeding to determine whether to impose a civil money penalty, assessment, or exclusion under subsection (a) or (b) only as authorized by the Attorney General pursuant to procedures agreed upon by them. The Secretary may not initiate an action under this section with respect to any claim, request for payment, or other occurrence described in this section later than six years after the date the claim was presented, the request for payment was made, or the occurrence took place. The Secretary may initiate an action under this section by serving notice of the action in any manner authorized by Rule 4 of the Federal Rules of Civil Procedure.

(2) The Secretary shall not make a determination adverse to any person under subsection (a) or (b) until the person has been given written notice and an opportunity for the determination to be made on the record after a hearing at which the person is entitled to be

represented by counsel, to present witnesses, and to cross-examine witnesses against the person.

(3) In a proceeding under subsection (a) or (b) which—

(A) is against a person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statements, and

(B) involves the same transaction as in the criminal action, the person is estopped from denying the essential elements of the criminal offense.

(4) The official conducting a hearing under this section may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing. Such sanction shall reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include—

(A) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established,

(B) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense,

(C) striking pleadings, in whole or in part,

(D) staying the proceedings,

(E) dismissal of the action,

(F) entering a default judgment,

(G) ordering the party or attorney to pay attorneys' fees and other costs caused by the failure or misconduct, and

(H) refusing to consider any motion or other action which is not filed in a timely manner.

(d) In determining the amount or scope of any penalty, assessment, or exclusion imposed pursuant to subsection (a) or (b), the Secretary shall take into account—

(1) the nature of claims and the circumstances under which they were presented,

(2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and

(3) such other matters as justice may require.

(e) Any person adversely affected by a determination of the Secretary under this section may obtain a review of such determination in the United States Court of Appeals for the circuit in which the person resides, or in which the claim or specified claim was presented, by filing in such court (within sixty days following the date the person is notified of the Secretary's determination) a written petition requesting that the determination be modified or set aside. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, and thereupon the Secretary shall file in the Court the record in the proceeding as provided in section 2112 of title 28, United States Code. Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined therein, and shall have the power to make and enter upon the pleadings, testimony, and proceedings set forth in such record a decree affirming, modifying, remanding for further consid-

eration, or setting aside, in whole or in part, the determination of the Secretary and enforcing the same to the extent that such order is affirmed or modified. No objection that has not been urged before the Secretary shall be considered by the court, unless the failure or neglect to urge such objection shall be excused because of extraordinary circumstances. The findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive. If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Secretary, the court may order such additional evidence to be taken before the Secretary and to be made a part of the record. The Secretary may modify his findings as to the facts, or make new findings, by reason of additional evidence so taken and filed, and he shall file with the court such modified or new findings, which findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order. Upon the filing of the record with it, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, except that the same shall be subject to review by the Supreme Court of the United States, as provided in section 1254 of title 28, United States Code.

(f) Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim or specified claim (as defined in subsection (r)) was presented, or where the claimant (or, with respect to a person described in subsection (o), the person) resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1)(A) In the case of amounts recovered arising out of a claim under title XIX, there shall be paid to the State agency an amount bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid for such claim.

(B) In the case of amounts recovered arising out of a claim under an allotment to a State under title V, there shall be paid to the State agency an amount equal to three-sevenths of the amount recovered.

(2) Such portion of the amounts recovered as is determined to have been paid out of the trust funds under sections 1817 and 1841 shall be repaid to such trust funds.

(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Insurance Portability and Accountability Act of 1996 (as estimated by the Secretary) shall be deposited

into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C).

(4) The remainder of the amounts recovered shall be deposited as miscellaneous receipts of the Treasury of the United States.

The amount of such penalty or assessment, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency (or, in the case of a penalty or assessment under subsection (o), by a specified State agency (as defined in subsection (q)(6)), to the person against whom the penalty or assessment has been assessed.

(g) A determination by the Secretary to impose a penalty, assessment, or exclusion under subsection (a) or (b) shall be final upon the expiration of the sixty-day period referred to in subsection (e). Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to subsection (e) may not be raised as a defense to a civil action by the United States to collect a penalty, assessment, or exclusion assessed under this section.

(h) Whenever the Secretary's determination to impose a penalty, assessment, or exclusion under subsection (a) or (b) becomes final, he shall notify the appropriate State or local medical or professional organization, the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1128(h)), and the appropriate utilization and quality control peer review organization, and the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33)) that such a penalty, assessment, or exclusion has become final and the reasons therefor.

(i) For the purposes of this section:

(1) The term "State agency" means the agency established or designated to administer or supervise the administration of the State plan under title XIX of this Act or designated to administer the State's program under title V or subtitle 1 of title XX of this Act.

(2) The term "claim" means an application for payments for items and services under a Federal health care program (as defined in section 1128B(f)).

(3) The term "item or service" includes (A) any particular item, device, medical supply, or service claimed to have been provided to a patient and listed in an itemized claim for payment, and (B) in the case of a claim based on costs, any entry in the cost report, books of account or other documents supporting such claim.

(4) The term "agency of the United States" includes any contractor acting as a fiscal intermediary, carrier, or fiscal agent or any other claims processing agent for a Federal health care program (as so defined).

(5) The term "beneficiary" means an individual who is eligible to receive items or services for which payment may be made under a Federal health care program (as so defined) but does not include a provider, supplier, or practitioner.

(6) The term “remuneration” includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term “remuneration” does not include—

(A) the waiver of coinsurance and deductible amounts by a person, if—

(i) the waiver is not offered as part of any advertisement or solicitation;

(ii) the person does not routinely waive coinsurance or deductible amounts; and

(iii) the person—

(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or

(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts;

(B) subject to subsection (n), any permissible practice described in any subparagraph of section 1128B(b)(3) or in regulations issued by the Secretary;

(C) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996;

(D) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated;

(E) a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B);

(F) any other remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs (as defined in section 1128B(f) and designated by the Secretary under regulations);

(G) the offer or transfer of items or services for free or less than fair market value by a person, if—

(i) the items or services consist of coupons, rebates, or other rewards from a retailer;

(ii) the items or services are offered or transferred on equal terms available to the general public, regardless of health insurance status; and

(iii) the offer or transfer of the items or services is not tied to the provision of other items or services reimbursed in whole or in part by the program under title XVIII or a State health care program (as defined in section 1128(h));

(H) the offer or transfer of items or services for free or less than fair market value by a person, if—

(i) the items or services are not offered as part of any advertisement or solicitation;

(ii) the items or services are not tied to the provision of other services reimbursed in whole or in part by the program under title XVIII or a State health care program (as so defined);

(iii) there is a reasonable connection between the items or services and the medical care of the individual; and

(iv) the person provides the items or services after determining in good faith that the individual is in financial need; or

(I) effective on a date specified by the Secretary (but not earlier than January 1, 2011), the waiver by a PDP sponsor of a prescription drug plan under part D of title XVIII or an MA organization offering an MA-PD plan under part C of such title of any copayment for the first fill of a covered part D drug (as defined in section 1860D-2(e)) that is a generic drug for individuals enrolled in the prescription drug plan or MA-PD plan, respectively.

(7) The term “should know” means that a person, with respect to information—

(A) acts in deliberate ignorance of the truth or falsity of the information; or

(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.

(j)(1) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.

(2) The Secretary may delegate authority granted under this section and under section 1128 to the Inspector General of the Department of Health and Human Services.

(k) Whenever the Secretary has reason to believe that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty under this section, the Secretary may bring an action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, encumbering, or disposing of assets which may be required in order to pay a civil monetary penalty if any such penalty were to be imposed or to seek other appropriate relief.

(l) A principal is liable for penalties, assessments, and an exclusion under this section for the actions of the principal’s agent acting within the scope of the agency.

(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section

shall be deemed to be references to the Inspector General of the applicable department or agency.

(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 (5 U.S.C. App.) with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.

(n)(1) Subparagraph (B) of subsection (i)(6) shall not apply to a practice described in paragraph (2) unless—

(A) the Secretary, through the Inspector General of the Department of Health and Human Services, promulgates a rule authorizing such a practice as an exception to remuneration; and

(B) the remuneration is offered or transferred by a person under such rule during the 2-year period beginning on the date the rule is first promulgated.

(2) A practice described in this paragraph is a practice under which a health care provider or facility pays, in whole or in part, premiums for medicare supplemental policies for individuals entitled to benefits under part A of title XVIII pursuant to section 226A.

(o) Any person (including an organization, agency, or other entity, but excluding a program beneficiary, as defined in subsection (q)(4)) that, with respect to a grant, contract, or other agreement for which the Secretary provides funding—

(1) knowingly presents or causes to be presented a specified claim (as defined in subsection (r)) under such grant, contract, or other agreement that the person knows or should know is false or fraudulent;

(2) knowingly makes, uses, or causes to be made or used any false statement, omission, or misrepresentation of a material fact in any application, proposal, bid, progress report, or other document that is required to be submitted in order to directly or indirectly receive or retain funds provided in whole or in part by such Secretary pursuant to such grant, contract, or other agreement;

(3) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent specified claim under such grant, contract, or other agreement;

(4) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation (as defined in subsection (s)) to pay or transmit funds or property to such Secretary with respect to such grant, contract, or other agreement, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit funds or property to such Secretary with respect to such grant, contract, or other agreement; or

(5) fails to grant timely access, upon reasonable request (as defined by such Secretary in regulations), to the Inspector General of the Department, for the purpose of audits, investigations, evaluations, or other statutory functions of such Inspector General in matters involving such grants, contracts, or other agreements;

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty in cases under paragraph (1), of not more than \$10,000 for each specified claim; in cases under paragraph (2), not more than \$50,000 for each false statement, omission, or misrepresentation of a material fact; in cases under paragraph (3), not more than \$50,000 for each false record or statement; in cases under paragraph (4), not more than \$50,000 for each false record or statement or \$10,000 for each day that the person knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay; or in cases under paragraph (5), not more than \$15,000 for each day of the failure described in such paragraph. In addition, in cases under paragraphs (1) and (3), such a person shall be subject to an assessment of not more than 3 times the amount claimed in the specified claim described in such paragraph in lieu of damages sustained by the United States or a specified State agency because of such specified claim, and in cases under paragraphs (2) and (4), such a person shall be subject to an assessment of not more than 3 times the total amount of the funds described in paragraph (2) or (4), respectively (or, in the case of an obligation to transmit property to the Secretary described in paragraph (4), of the value of the property described in such paragraph) in lieu of damages sustained by the United States or a specified State agency because of such case. In addition, the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1128B(f)(1)) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

(p) The provisions of subsections (c), (d), (g), and (h) shall apply to a civil money penalty or assessment under subsection (o) in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a). In applying subsection (d), each reference to a claim under such subsection shall be treated as including a reference to a specified claim (as defined in subsection (r)).

(q) For purposes of this subsection and subsections (o) and (p):

(1) The term "Department" means the Department of Health and Human Services.

(2) The term “material” means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(3) The term “other agreement” includes a cooperative agreement, scholarship, fellowship, loan, subsidy, payment for a specified use, donation agreement, award, or subaward (regardless of whether one or more of the persons entering into the agreement is a contractor or subcontractor).

(4) The term “program beneficiary” means, in the case of a grant, contract, or other agreement designed to accomplish the objective of awarding or otherwise furnishing benefits or assistance to individuals and for which the Secretary provides funding, an individual who applies for, or who receives, such benefits or assistance from such grant, contract, or other agreement. Such term does not include, with respect to such grant, contract, or other agreement, an officer, employee, or agent of a person or entity that receives such grant or that enters into such contract or other agreement.

(5) The term “recipient” includes a subrecipient or subcontractor.

(6) The term “specified State agency” means an agency of a State government established or designated to administer or supervise the administration of a grant, contract, or other agreement funded in whole or in part by the Secretary.

(r) For purposes of this section, the term “specified claim” means any application, request, or demand under a grant, contract, or other agreement for money or property, whether or not the United States or a specified State agency has title to the money or property, that is not a claim (as defined in subsection (i)(2)) and that—

(1) is presented or caused to be presented to an officer, employee, or agent of the Department or agency thereof, or of any specified State agency; or

(2) is made to a contractor, grantee, or any other recipient if the money or property is to be spent or used on the Department’s behalf or to advance a Department program or interest, and if the Department—

(A) provides or has provided any portion of the money or property requested or demanded; or

(B) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

(s) For purposes of subsection (o), the term “obligation” means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, for a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment.

* * * * *

INCOME AND ELIGIBILITY VERIFICATION SYSTEM

SEC. 1137. (a) In order to meet the requirements of this section, a State must have in effect an income and eligibility verification system which meets the requirements of subsection (d) and under which—

(1) the State shall require, as a condition of eligibility for benefits under any program listed in subsection (b), that each applicant for or recipient of benefits under that program furnish to the State his social security account number (or numbers, if he has more than one such number), and the State shall utilize such account numbers in the administration of that program so as to enable the association of the records pertaining to the applicant or recipient with his account number;

(2) wage information from agencies administering State unemployment compensation laws available pursuant to section 3304(a)(16) of the Internal Revenue Code of 1954, wage information reported pursuant to paragraph (3) of this subsection, and wage, income, and other information from the Social Security Administration and the Internal Revenue Service available pursuant to section 6103(l)(7) of such Code, shall be requested and utilized to the extent that such information may be useful in verifying eligibility for, and the amount of, benefits available under any program listed in subsection (b), as determined by the Secretary of Health and Human Services (or, in the case of the unemployment compensation program, by the Secretary of Labor, or, in the case of the supplemental nutrition assistance program, by the Secretary of Agriculture);

(3) employers (as defined in section 453A(a)(2)(B)) (including State and local governmental entities and labor organizations (as defined in section 453A(a)(2)(B)(ii))) in such State are required, effective September 30, 1988, to make quarterly wage reports to a State agency (which may be the agency administering the State's unemployment compensation law) except that the Secretary of Labor (in consultation with the Secretary of Health and Human Services and the Secretary of Agriculture) may waive the provisions of this paragraph if he determines that the State has in effect an alternative system which is as effective and timely for purposes of providing employment related income and eligibility data for the purposes described in paragraph (2), and except that no report shall be filed with respect to an employee of a State or local agency performing intelligence or counterintelligence functions, if the head of such agency has determined that filing such a report could endanger the safety of the employee or compromise an ongoing investigation or intelligence mission, and except that in the case of wage reports with respect to domestic service employment, a State may permit employers (as so defined) that make returns with respect to such employment on a calendar year basis pursuant to section 3510 of the Internal Revenue Code of 1986 to make such reports on an annual basis;

(4) the State agencies administering the programs listed in subsection (b) adhere to standardized formats and procedures established by the Secretary of Health and Human Services (in consultation with the Secretary of Agriculture) under which—

(A) the agencies will exchange with each other information in their possession which may be of use in establishing or verifying eligibility or benefit amounts under any other such program;

(B) such information shall be made available to assist in the child support program under part D of title IV of this Act, and to assist the Secretary of Health and Human Services in establishing or verifying eligibility or benefit amounts under titles II and XVI of this Act, but subject to the safeguards and restrictions established by the Secretary of the Treasury with respect to information released pursuant to section 6103(l) of the Internal Revenue Code of 1954; and

(C) the use of such information shall be targeted to those uses which are most likely to be productive in identifying and preventing ineligibility and incorrect payments, and no State shall be required to use such information to verify the eligibility of all recipients;

(5) adequate safeguards are in effect so as to assure that—

(A) the information exchanged by the State agencies is made available only to the extent necessary to assist in the valid administrative needs of the program receiving such information, and the information released pursuant to section 6103(l) of the Internal Revenue Code of 1954 is only exchanged with agencies authorized to receive such information under such section 6103(l); and

(B) the information is adequately protected against unauthorized disclosure for other purposes, as provided in regulations established by the Secretary of Health and Human Services, or, in the case of the unemployment compensation program, the Secretary of Labor, or, in the case of the supplemental nutrition assistance program, the Secretary of Agriculture, or in the case of information released pursuant to section 6103(l) of the Internal Revenue Code of 1954, the Secretary of the Treasury;

(6) all applicants for and recipients of benefits under any such program shall be notified at the time of application, and periodically thereafter, that information available through the system will be requested and utilized; and

(7) accounting systems are utilized which assure that programs providing data receive appropriate reimbursement from the programs utilizing the data for the costs incurred in providing the data.

(b) The programs which must participate in the income and eligibility verification system are—

(1) any State program funded under part A of title IV of this Act;

(2) the medicaid program under title XIX of this Act;

(3) the unemployment compensation program under section 3304 of the Internal Revenue Code of 1954;

(4) the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.); and

(5) any State program under a plan approved under title I, X, XIV, or XVI of this Act.

(c)(1) In order to protect applicants for and recipients of benefits under the programs identified in subsection (b), or under the supplemental security income program under title XVI, from the im-

proper use of information obtained from the Secretary of the Treasury under section 6103(l)(7)(B) of the Internal Revenue Code of 1954, no Federal, State, or local agency receiving such information may terminate, deny, suspend, or reduce any benefits of an individual until such agency has taken appropriate steps to independently verify information relating to—

(A) the amount of the asset or income involved,

(B) whether such individual actually has (or had) access to such asset or income for his own use, and

(C) the period or periods when the individual actually had such asset or income.

(2) Such individual shall be informed by the agency of the findings made by the agency on the basis of such verified information, and shall be given an opportunity to contest such findings, in the same manner as applies to other information and findings relating to eligibility factors under the program.

(d) The requirements of this subsection, with respect to an income and eligibility verification system of a State, are as follows:

(1)(A) The State shall require, as a condition of an individual's eligibility for benefits under a program listed in subsection (b), a declaration in writing, under penalty of perjury—

(i) by the individual,

(ii) in the case in which eligibility for program benefits is determined on a family or household basis, by any adult member of such individual's family or household (as applicable), or

(iii) in the case of an individual born into a family or household receiving benefits under such program, by any adult member or such family or household no later than the next redetermination of eligibility of such family or household following the birth of such individual,

stating whether the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is in a satisfactory immigration status.

(B) In this subsection, in the case of the program described in subsection (b)(4)—

(i) any reference to the State shall be considered a reference to the State agency, and

(ii) any reference to an individual's eligibility for benefits under the program shall be considered a reference to the individual's eligibility to participate in the program as a member of a household, and

(iii) the term "satisfactory immigration status" means an immigration status which does not make the individual ineligible for benefits under the applicable program.

(2) If such an individual is not a citizen or national of the United States, there must be presented either—

(A) alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or

(B) such other documents as the State determines constitutes reasonable evidence indicating a satisfactory immigration status.

(3) If the documentation described in paragraph (2)(A) is presented, the State shall utilize the individual's alien file or alien admission number to verify with the Immigration and Naturalization Service the individual's immigration status through an automated or other system (designated by the Service for use with States) that—

(A) utilizes the individual's name, file number, admission number, or other means permitting efficient verification, and

(B) protects the individual's privacy to the maximum degree possible.

(4) In the case of such an individual who is not a citizen or national of the United States, if, at the time of application for benefits, the statement described in paragraph (1) is submitted but the documentation required under paragraph (2) is not presented or if the documentation required under paragraph (2)(A) is presented but such documentation is not verified under paragraph (3)—

(A) *subject to subsection (f)(2)*, the State—

(i) shall provide a reasonable opportunity to submit to the State evidence indicating a satisfactory immigration status, and

(ii) may not delay, deny, reduce, or terminate the individual's eligibility for benefits under the program on the basis of the individual's immigration status until such a reasonable opportunity has been provided; and

(B) if there are submitted documents which the State determines constitutes reasonable evidence indicating such status—

(i) the State shall transmit to the Immigration and Naturalization Service either photostatic or other similar copies of such documents, or information from such documents, as specified by the Immigration and Naturalization Service, for official verification,

(ii) *subject to subsection (f)(2)*, pending such verification, the State may not delay, deny, reduce, or terminate the individual's eligibility for benefits under the program on the basis of the individual's immigration status, and

(iii) the State shall not be liable for the consequences of any action, delay, or failure of the Service to conduct such verification.

(5) If the State determines, after complying with the requirements of paragraph (4), that such an individual is not in a satisfactory immigration status under the applicable program—

(A) the State shall deny or terminate the individual's eligibility for benefits under the program, and

(B) the applicable fair hearing process shall be made available with respect to the individual.

(e) Each Federal agency responsible for administration of a program described in subsection (b) shall not take any compliance, dis-

allowance, penalty, or other regulatory action against a State with respect to any error in the State's determination to make an individual eligible for benefits based on citizenship or immigration status—

(1) if the State has provided such eligibility based on a verification of satisfactory immigration status by the Immigration and Naturalization Service,

(2) because the State, under subsection (d)(4)(A)(ii), was required to provide a reasonable opportunity to submit documentation,

(3) because the State, under subsection (d)(4)(B)(ii), was required to wait for the response of the Immigration and Naturalization Service to the State's request for official verification of the immigration status of the individual, or

(4) because of a fair hearing process described in subsection (d)(5)(B).

(f) **Subsections (a)(1) and (d)** (1) *Subsections (a)(1) and (d)* shall not apply with respect to aliens seeking medical assistance for the treatment of an emergency medical condition under section 1903(v)(2).

(2)(A) *Subparagraphs (A) and (B)(ii) of subsection (d)(4) shall not apply in the case of an initial determination made on or after the date that is 6 months after the date of the enactment of this paragraph with respect to the eligibility of an alien described in subparagraph (B) for benefits under the program listed in subsection (b)(2).*

(B) *An alien described in this subparagraph is an individual declaring to be a citizen or national of the United States with respect to whom a State, in accordance with section 1902(a)(46)(B), requires—*

(i) pursuant to 1902(ee), the submission of a social security number; or

(ii) pursuant to 1903(x), the presentation of satisfactory documentary evidence of citizenship or nationality.

* * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1903 are authorized by this title; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will as-

sure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, (C) that each State or local officer, employee, or independent contractor who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer, employee, or contractor, and each partner of such an officer, employee, or contractor shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, United States Code, and (D) that each State or local officer, employee, or independent contractor who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) to persons described in subsection (a)(2) of such section of that Act;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under title I or XVI (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under title XVI, or by the agency or agencies ad-

ministering the supplemental security income program established under title XVI or the State plan approved under part A of title IV if the State is not eligible to participate in the State plan program established under title XVI;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide—

(A) safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with—

(i) the administration of the plan; and

(ii) the exchange of information necessary to certify or verify the certification of eligibility of children for free or reduced price breakfasts under the Child Nutrition Act of 1966 and free or reduced price lunches under the Richard B. Russell National School Lunch Act, in accordance with section 9(b) of that Act, using data standards and formats established by the State agency; and

(B) that, notwithstanding the Express Lane option under subsection (e)(13), the State may enter into an agreement with the State agency administering the school lunch program established under the Richard B. Russell National School Lunch Act under which the State shall establish procedures to ensure that—

(i) a child receiving medical assistance under the State plan under this title whose family income does not exceed 133 percent of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act, including any revision required by such section), as determined without regard to any expense, block, or other income disregard, applicable to a family of the size involved, may be certified as eligible for free lunches under the Richard B. Russell National School Lunch Act and free breakfasts under the Child Nutrition Act of 1966 without further application; and

(ii) the State agencies responsible for administering the State plan under this title, and for carrying out the school lunch program established under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.) or the school breakfast program established by section 4 of the Child Nutrition Act of 1966 (42 U.S.C. 1773), cooperate in carrying out paragraphs (3)(F) and (15) of section 9(b) of that Act;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Sec-

retary for the purpose specified in the first sentence of section 1864(a)), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions,

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1861(e)(9) or paragraphs (16) and (17) of section 1861(s), or, in the case of a laboratory which is in a rural health clinic, of section 1861(aa)(2)(G), and

(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term care options and the quality of care provided by individual facilities;

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17), (21), and (28) of section 1905(a), to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV (including individuals eligible under this title by reason of section 402(a)(37), 406(h), or 473(b), or considered by the State to be receiving such aid as authorized under section 482(e)(6)),

(II)(aa) with respect to whom supplemental security income benefits are being paid under title XVI (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193) and would continue to be paid but for the enactment of that section), (bb) who are qualified severely impaired individuals (as defined in section 1905(q)), or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under title XVI if subparagraphs (A) and (B) of section 1611(c)(7) were applied without regard to the phrase “the first day of the month following”,

(III) who are qualified pregnant women or children as defined in section 1905(n),

(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) for such a family;

(V) who are qualified family members as defined in section 1905(m)(1),

(VI) who are described in subparagraph (C) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) for such a family,

(VII) who are described in subparagraph (D) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) for such a family;

(VIII) beginning January 1, 2014, *at the option of a State*, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k); or

(IX) who—

(aa) are under 26 years of age;

(bb) are not described in or enrolled under any of subclauses (I) through (VII) of this clause or are described in any of such subclauses but have income that exceeds the level of income applicable under the State plan for eligibility to enroll for medical assistance under such subclause;

(cc) were in foster care under the responsibility of the State on the date of attaining 18 years of age or such higher age as the State has elected under section 475(8)(B)(iii); and

(dd) were enrolled in the State plan under this title or under a waiver of the plan while in such foster care;

(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) (or, in the case of individuals described in section 1905(a)(i), to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under title XVI, or a State supplementary payment;

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1903(f)(4)(C),

(VI) who would be eligible under the State plan under this title if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1915 they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1915,

(VII) who would be eligible under the State plan under this title if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1905(o);

(VIII) who is a child described in section 1905(a)(i)—

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of title IV) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical

assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of title IV were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of title IV;

(IX) who are described in subsection (l)(1) and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII);

(X) who are described in subsection (m)(1);

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under title XVI), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under section 1616 or 1634;

(XII) who are described in subsection (z)(1) (relating to certain TB-infected individuals);

(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security income (subject, notwithstanding section 1916, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);

(XIV) who are optional targeted low-income children described in section 1905(u)(2)(B);

(XV) who, but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security

income, who is at least 16, but less than 65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish;

(XVI) who are employed individuals with a medically improved disability described in section 1905(v)(1) and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, but only if the State provides medical assistance to individuals described in subclause (XV);

(XVII) who are independent foster care adolescents (as defined in section 1905(w)(1)), or who are within any reasonable categories of such adolescents specified by the State;

(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);

(XIX) who are disabled children described in subsection (cc)(1);

(XX) beginning January 1, 2014, *and ending December 31, 2019*, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);

(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards); or

(XXII) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A) or (E), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance—

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) or the care and services listed in any 7 of the paragraphs numbered (1) through (24) of such section;

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services;

(E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3)) for qualified medicare beneficiaries described in section 1905(p)(1);

(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1905(p)(3)(A)(i) for qualified disabled and working individuals described in section 1905(s);

(iii) for making medical assistance available for medicare cost sharing described in section 1905(p)(3)(A)(ii) subject to

section 1905(p)(4), for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; and

(iv) subject to sections 1933 and 1905(p)(4), for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;

(F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2)) for qualified COBRA continuation beneficiaries described in section 1902(u)(1); and

(G) that, in applying eligibility criteria of the supplemental security income program under title XVI for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving supplemental security income, the State will disregard the provisions of subsections (c) and (e) of section 1613;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of

such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916(a)(2) or (b)(2) shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under title XVIII, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (l)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1905(p)(1) who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1905(p)(3)), subject to the provisions of subsection (n) and section 1916(b), (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1923(a)(1)(A), as a disproportionate share hospital and sub-

paragraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1906 shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals, (XII) the medical assistance made available to an individual described in subsection (u)(1) who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2)), (XIII) the medical assistance made available to an individual described in subsection (z)(1) who is eligible for medical assistance only because of subparagraph (A)(ii)(XII) shall be limited to medical assistance for TB-related services (described in subsection (z)(2)), (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1), (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting and (XVII) if an individual is described in subclause (IX) of subparagraph (A)(i) and is also described in subclause (VIII) of that subparagraph, the medical assistance shall be made available to the individual through subclause (IX) instead of through subclause (VIII);

(11)(A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, (B) provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments under (or through an allotment under) title V, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such title or allotment and which are included in the State plan approved under this section (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to the individual under section 1903, and (iii) providing for coordination of information and education on pediatric vaccinations

and delivery of immunization services, and (C) provide for coordination of the operations under this title, including the provision of information and education on pediatric vaccinations and the delivery of immunization services, with the State's operations under the special supplemental nutrition program for women, infants, and children under section 17 of the Child Nutrition Act of 1966;

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide—

(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—

(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,

(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs;

(B) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of title XVIII and for payment of amounts under section 1905(o)(3); except that in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual; and

(C) payment for primary care services (as defined in subsection (jj)) furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent of the payment rate that applies to such services and physician under part B of title XVIII (or, if greater, the payment rate that would be applicable under such part if the conversion factor under section

1848(d) for the year involved were the conversion factor under such section for 2009);

(14) provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1916;

(15) provide for payment for services described in clause (B) or (C) of section 1905(a)(2) under the plan in accordance with subsection (bb);

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) except as provided in subsections (e)(14), ~~[(e)(14)]~~ (e)(15), (l)(3), (m)(3), and (m)(4), include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or to have paid with respect to him supplemental security income benefits under title XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1903(f)(2)(B), or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

(18) comply with the provisions of section 1917 with respect to liens, adjustments and recoveries of medical assistance correctly paid, transfers of assets, and treatment of certain trusts;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 3(a)(4)(A)(i) and (ii) or section 1603(a)(4)(A)(i) and (ii) which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the

State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

(23) provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1915(b)(1)), a medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1905(a)(4)(C), except as provided in subsection (g) and in section 1915, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan or by a provider or supplier to which a moratorium under subsection (kk)(4) is applied during the period of such moratorium’;

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this Act, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this Act, and (C) to provide information needed to determine payments due under this Act on account of care and services furnished to individuals;

(25) provide—

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including—

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1903(r);

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1916), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1916, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1916) exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1905(a)(4)(B)) covered under the State plan, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services, except that the State may, if the State determines doing so is cost-effective and will not adversely affect access to care, only make such payment if a third party so liable has not made payment within 90 days after the date the provider of such services has initially submitted a

claim to such third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of title IV of this Act, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care;

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this title for such State, or any other State;

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to any payments by such third party; and

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a

health care item or service, as a condition of doing business in the State, to—

(i) provide, with respect to individuals who are eligible (and, at State option, individuals who apply or whose eligibility for medical assistance is being evaluated in accordance with section 1902(e)(13)(D)) for, or are provided, medical assistance under the State plan under this title (and, at State option, child health assistance under title XXI), upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

(ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if—

(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

(26) if the State plan includes medical assistance for inpatient mental hospital services, provide, with respect to each patient receiving such services, for a regular program of medical review (including medical evaluation) of his need for such services, and for a written plan of care;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

(28) provide—

(A) that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections

(b) through (d) of section 1919 as they apply to such facilities;

(B) for including in “nursing facility services” at least the items and services specified (or deemed to be specified) by the Secretary under section 1919(f)(7) and making available upon request a description of the items and services so included;

(C) for procedures to make available to the public the data and methodology used in establishing payment rates for nursing facilities under this title; and

(D) for compliance (by the date specified in the respective sections) with the requirements of—

(i) section 1919(e);

(ii) section 1919(g) (relating to responsibility for survey and certification of nursing facilities); and

(iii) sections 1919(h)(2)(B) and 1919(h)(2)(D) (relating to establishment and application of remedies);

(29) include a State program which meets the requirements set forth in section 1908, for the licensing of administrators of nursing homes;

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and

(B) provide, under the program described in subparagraph (A), that—

(i) each admission to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved, and

(ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (II) subjecting admissions to early or more extensive review where information indi-

cates that such consideration is warranted to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases;

(31) with respect to services in an intermediate care facility for the mentally retarded (where the State plan includes medical assistance for such services) provide, with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment;

(C) in the case of services furnished (during a period that does not exceed 14 continuous days in the case of an informal reciprocal arrangement or 90 continuous days (or such longer period as the Secretary may provide) in the case of an arrangement involving per diem or other fee-for-time compensation) by, or incident to the services of, one physician to the patients of another physician who submits the claim for such services, payment shall be made to the physician submitting the claim (as if the services were furnished by, or incident to, the physician's services), but only

if the claim identifies (in a manner specified by the Secretary) the physician who furnished the services; and

(D) in the case of payment for a childhood vaccine administered before October 1, 1994, to individuals entitled to medical assistance under the State plan, the State plan may make payment directly to the manufacturer of the vaccine under a voluntary replacement program agreed to by the State pursuant to which the manufacturer (i) supplies doses of the vaccine to providers administering the vaccine, (ii) periodically replaces the supply of the vaccine, and (iii) charges the State the manufacturer's price to the Centers for Disease Control and Prevention for the vaccine so administered (which price includes a reasonable amount to cover shipping and the handling of returns);

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the second sentence of this subsection; and

(B) that, except as provided in section 1919(g), the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished [in or after the third month before the month in which he made application] *in or after the month in which the individual made application* (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) provide that any disclosing entity (as defined in section 1124(a)(2)) receiving payments under such plan complies with the requirements of section 1124;

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this title, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, the information described in section 1128(b)(9);

(39) provide that the State agency shall exclude any specified individual or entity from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1128 or section 1128A, terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1128(c)(3)(B) and 1128(d)(3)(B)) participation of such individual or entity is terminated under title XVIII, any other State plan under this title (or waiver of the plan), or any State child health plan under title XXI (or waiver of the plan) and such termination is included by the Secretary in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act, and provide that no payment may be

made under the plan with respect to any item or service furnished by such individual or entity during such period;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization;

(41) provide, in accordance with subsection (kk)(8) (as applicable), that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board of such action;

(42) provide that—

(A) the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan; and

(B) not later than December 31, 2010, the State shall—

(i) establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1893(h), subject to such exceptions or requirements as the Secretary may require for purposes of this title or a particular State) with 1 or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver; and

(ii) provide assurances satisfactory to the Secretary that—

(I) under such contracts, payment shall be made to such a contractor only from amounts recovered;

(II) from such amounts recovered, payment—

(aa) shall be made on a contingent basis for collecting overpayments; and

(bb) may be made in such amounts as the State may specify for identifying underpayments;

(III) the State has an adequate process for entities to appeal any adverse determination made by such contractors; and

(IV) such program is carried out in accordance with such requirements as the Secretary shall specify, including—

(aa) for purposes of section 1903(a)(7), that amounts expended by the State to carry out the program shall be considered amounts ex-

pended as necessary for the proper and efficient administration of the State plan or a waiver of the plan;

(bb) that section 1903(d) shall apply to amounts recovered under the program; and

(cc) that the State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, including efforts with Federal and State law enforcement with respect to the Department of Justice, including the Federal Bureau of Investigations, the Inspector General of the Department of Health and Human Services, and the State medicaid fraud control unit; and

(43) provide for—

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1905(a)(4)(B), of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1905(r) and the need for age-appropriate immunizations against vaccine-preventable diseases,

(B) providing or arranging for the provision of such screening services in all cases where they are requested,

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services, and

(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:

(i) the number of children provided child health screening services,

(ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),

(iii) the number of children receiving dental services, and other information relating to the provision of dental services to such children described in section 2108(e) and

(iv) the State's results in attaining the participation goals set for the State under section 1905(r);

(44) in each case for which payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded, or inpatient mental hospital services is made under the State plan—

(A) a physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under section 1903(g)(6) (or, in the case of services that are services provided in an intermediate care facility for the mentally retarded, every year), and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

(B) such services were furnished under a plan established and periodically reviewed and evaluated by a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician;

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1912;

(46)(A) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act; and

(B) provide, with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this title, that the State shall satisfy the requirements of—

(i) section 1903(x); or

(ii) subsection (ee);

(47) provide—

(A) at the option of the State, for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1920 and provide for making medical assistance for items and services described in subsection (a) of section 1920A available to children during a presumptive eligibility period in accordance with such section and provide for making medical assistance available to individuals described in subsection (a) of section 1920B during a presumptive eligibility period in accordance with such section and provide for making medical assistance available to individuals de-

scribed in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section; and

(B) that any hospital that is a participating provider under the State plan may elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period, in the same manner, and subject to the same requirements, as apply to the State options with respect to populations described in section 1920, 1920A, 1920B, or 1920C (but without regard to whether the State has elected to provide for a presumptive eligibility period under any such sections), subject to such guidance as the Secretary shall establish *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;*

(48) provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(49) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921;

(50) provide, in accordance with subsection (q), for a monthly personal needs allowance for certain institutionalized individuals and couples;

(51) meet the requirements of section 1924 (relating to protection of community spouses);

(52) meet the requirements of section 1925 (relating to extension of eligibility for medical assistance);

(53) provide—

(A) for notifying in a timely manner all individuals in the State who are determined to be eligible for medical assistance and who are pregnant women, breastfeeding or postpartum women (as defined in section 17 of the Child Nutrition Act of 1966), or children below the age of 5, of the availability of benefits furnished by the special supplemental nutrition program under such section, and

(B) for referring any such individual to the State agency responsible for administering such program;

(54) in the case of a State plan that provides medical assistance for covered outpatient drugs (as defined in section 1927(k)), comply with the applicable requirements of section 1927;

(55) provide for receipt and initial processing of applications of individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)—

(A) at locations which are other than those used for the receipt and processing of applications for aid under part A

of title IV and which include facilities defined as disproportionate share hospitals under section 1923(a)(1)(A) and Federally-qualified health centers described in section 1905(1)(2)(B), and

(B) using applications which are other than those used for applications for aid under such part;

(56) provide, in accordance with subsection (s), for adjusted payments for certain inpatient hospital services;

(57) provide that each hospital, nursing facility, provider of home health care or personal care services, hospice program, or medicaid managed care organization (as defined in section 1903(m)(1)(A)) receiving funds under the plan shall comply with the requirements of subsection (w);

(58) provide that the State, acting through a State agency, association, or other private nonprofit entity, develop a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives that would be distributed by providers or organizations under the requirements of subsection (w);

(59) maintain a list (updated not less often than monthly, and containing each physician's unique identifier provided under the system established under subsection (x)) of all physicians who are certified to participate under the State plan;

(60) provide that the State agency shall provide assurances satisfactory to the Secretary that the State has in effect the laws relating to medical child support required under section 1908A;

(61) provide that the State must demonstrate that it operates a medicaid fraud and abuse control unit described in section 1903(q) that effectively carries out the functions and requirements described in such section, as determined in accordance with standards established by the Secretary, unless the State demonstrates to the satisfaction of the Secretary that the effective operation of such a unit in the State would not be cost-effective because minimal fraud exists in connection with the provision of covered services to eligible individuals under the State plan, and that beneficiaries under the plan will be protected from abuse and neglect in connection with the provision of medical assistance under the plan without the existence of such a unit;

(62) provide for a program for the distribution of pediatric vaccines to program-registered providers for the immunization of vaccine-eligible children in accordance with section 1928;

(63) provide for administration and determinations of eligibility with respect to individuals who are (or seek to be) eligible for medical assistance based on the application of section 1931;

(64) provide, not later than 1 year after the date of the enactment of this paragraph, a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title;

(65) provide that the State shall issue provider numbers for all suppliers of medical assistance consisting of durable med-

ical equipment, as defined in section 1861(n), and the State shall not issue or renew such a supplier number for any such supplier unless—

(A)(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

(B) a surety bond in a form specified by the Secretary under section 1834(a)(16)(B) and in an amount that is not less than \$50,000 or such comparable surety bond as the Secretary may permit under the second sentence of such section;

(66) provide for making eligibility determinations under section 1935(a);

(67) provide, with respect to services covered under the State plan (but not under title XVIII) that are furnished to a PACE program eligible individual enrolled with a PACE provider by a provider participating under the State plan that does not have a contract or other agreement with the PACE provider that establishes payment amounts for such services, that such participating provider may not require the PACE provider to pay the participating provider an amount greater than the amount that would otherwise be payable for the service to the participating provider under the State plan for the State where the PACE provider is located (in accordance with regulations issued by the Secretary);

(68) provide that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall—

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph

(A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

(69) provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936;

(70) at the option of the State and notwithstanding paragraphs (1), (10)(B), and (23), provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide transportation for individuals eligible for medical assistance under the State plan who need access to medical care or services and have no other means of transportation which—

(A) may include a wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation, and such other transportation as the Secretary determines appropriate; and

(B) may be conducted under contract with a broker who—

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;

(ii) has oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous;

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services; and

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate);

(71) provide that the State will implement an asset verification program as required under section 1940;

(72) provide that the State will not prevent a Federally-qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services;

(73) in the case of any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that—

(A) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and pro-

posals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations; and

(B) may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its State plan under this title;

(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg); and

(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan;

(76) provide that any data collected under the State plan meets the requirements of section 3101 of the Public Health Service Act;

(77) provide that the State shall comply with provider and supplier screening, oversight, and reporting requirements in accordance with subsection (kk);

(78) provide that, not later than January 1, 2017, in the case of a State that pursuant to its State plan or waiver of the plan for medical assistance pays for medical assistance on a fee-for-service basis, the State shall require each provider furnishing items and services to, or ordering, prescribing, referring, or certifying eligibility for, services for individuals eligible to receive medical assistance under such plan to enroll with the State agency and provide to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier (if applicable), Federal taxpayer identification number, and the State license or certification number of the provider (if applicable);

(79) provide that any agent, clearinghouse, or other alternate payee (as defined by the Secretary) that submits claims on behalf of a health care provider must register with the State and the Secretary in a form and manner specified by the Secretary;

(80) provide that the State shall not provide any payments for items or services provided under the State plan or under

a waiver to any financial institution or entity located outside of the United States;

(81) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State;

(82) provide that the State agency responsible for administering the State plan under this title provides assurances to the Secretary that the State agency is in compliance with subparagraphs (A), (B), and (C) of section 1128K(b)(2); and

(83) provide that, not later than January 1, 2017, in the case of a State plan (or waiver of the plan) that provides medical assistance on a fee-for-service basis or through a primary care case-management system described in section 1915(b)(1) (other than a primary care case management entity (as defined by the Secretary)), the State shall publish (and update on at least an annual basis) on the public website of the State agency administering the State plan, a directory of the physicians described in subsection (mm) and, at State option, other providers described in such subsection that—

(A) includes—

(i) with respect to each such physician or provider—

(I) the name of the physician or provider;

(II) the specialty of the physician or provider;

(III) the address at which the physician or provider provides services; and

(IV) the telephone number of the physician or provider; and

(ii) with respect to any such physician or provider participating in such a primary care case-management system, information regarding—

(I) whether the physician or provider is accepting as new patients individuals who receive medical assistance under this title; and

(II) the physician's or provider's cultural and linguistic capabilities, including the languages spoken by the physician or provider or by the skilled medical interpreter providing interpretation services at the physician's or provider's office; and

(B) may include, at State option, with respect to each such physician or provider—

(i) the Internet website of such physician or provider; or

(ii) whether the physician or provider is accepting as new patients individuals who receive medical assistance under this title.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the

State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)). The provisions of paragraphs (9)(A), (31), and (33) and of section 1903(i)(4) shall not apply to a religious nonmedical health care institution (as defined in section 1861(ss)(1)).

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV and who for such month was entitled to monthly insurance benefits under title II shall for purposes of this title only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under title II resulting from enactment of Public Law 92-336 not been applicable to such individual.

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement. For purposes of this title, any child who meets the requirements of paragraph (1) or (2) of section 473(b) shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of title IV in the State where such child resides. Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1903(v).

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—

- (1) an age requirement of more than 65 years; or
- (2) any residence requirement which excludes any individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address; or
- (3) any citizenship requirement which excludes any citizen of the United States.

(c) Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if the State requires individuals described in subsection (1)(1) to apply for assistance under the State program funded under part A of title IV as a condition of applying for or receiving medical assistance under this title.

(d) If a State contracts with an entity which meets the requirements of section 1152, as determined by the Secretary, or a utilization and quality control peer review organization having a contract with the Secretary under part B of title XI for the performance of medical or utilization review functions (including quality review functions described in subsection (a)(30)(C)) required under this title of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to such an entity or organization under the contract of the State's authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of title XI and provides for such assurances of satisfactory performance by such an entity or organization as the Secretary may prescribe.

(e)(1) Beginning April 1, 1990, for provisions relating to the extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of title IV and have earned income, see section 1925.

(2)(A) In the case of an individual who is enrolled with a medicaid managed care organization (as defined in section 1903(m)(1)(A)), with a primary care case manager (as defined in section 1905(t)), or with an eligible organization with a contract under section 1876 and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but, except for benefits furnished under section 1905(a)(4)(C), only with respect to such benefits provided to the individual as an enrollee of such organization or entity or by or through the case manager.

(B) For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an individual's enrollment with an organization or entity under a State plan, a period, established by the State, of not more than six months beginning on the date the individual's enrollment with the organization or entity becomes effective.

(3) At the option of the State, any individual who—

(A) is 18 years of age or younger and qualifies as a disabled individual under section 1614(a);

(B) with respect to whom there has been a determination by the State that—

(i) the individual requires a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded,

(ii) it is appropriate to provide such care for the individual outside such an institution, and

(iii) the estimated amount which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution; and

(C) if the individual were in a medical institution, would be eligible for medical assistance under the State plan under this title, shall be deemed, for purposes of this title only, to be an individual with respect to whom a supplemental security income payment, or State supplemental payment, respectively, is being paid under title XVI.

(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year. During the period in which a child is deemed under the preceding sentence to be eligible for medical assistance, the medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires). Notwithstanding the preceding sentence, in the case of a child who is born in the United States to an alien mother for whom medical assistance for the delivery of the child is made available pursuant to section 1903(v), the State immediately shall issue a separate identification number for the child upon notification by the facility at which such delivery occurred of the child's birth.

(5) A woman who, while pregnant, is eligible for, has applied for, and has received medical assistance under the State plan, shall continue to be eligible under the plan, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan, through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

(6) In the case of a pregnant woman described in subsection (a)(10) who, because of a change in income of the family of which she is a member, would not otherwise continue to be described in such subsection, the woman shall be deemed to continue to be an individual described in subsection (a)(10)(A)(i)(IV) and subsection (1)(1)(A) without regard to such change of income through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends. The preceding sentence shall not apply in the case of a woman who has been provided ambulatory prenatal care pursuant to section 1920 during a presumptive eligibility period and is then, in accordance with such section, determined to be ineligible for medical assistance under the State plan.

(7) In the case of an infant or child described in subparagraph (B), (C), or (D) of subsection (1)(1) or paragraph (2) of section 1905(n)—

(A) who is receiving inpatient services for which medical assistance is provided on the date the infant or child attains the maximum age with respect to which coverage is provided under the State plan for such individuals, and

(B) who, but for attaining such age, would remain eligible for medical assistance under such subsection,

the infant or child shall continue to be treated as an individual described in such respective provision until the end of the stay for which the inpatient services are furnished.

(8) If an individual is determined to be a qualified medicare beneficiary (as defined in section 1905(p)(1)), such determination shall apply to services furnished after the end of the month in which the determination first occurs. For purposes of payment to a State under section 1903(a), such determination shall be considered to be valid for an individual for a period of 12 months, except that a State may provide for such determinations more frequently, but not more frequently than once every 6 months for an individual.

(9)(A) At the option of the State, the plan may include as medical assistance respiratory care services for any individual who—

(i) is medically dependent on a ventilator for life support at least six hours per day;

(ii) has been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, whichever is less) as an inpatient;

(iii) but for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, nursing facility, or intermediate care facility for the mentally retarded and would be eligible to have payment made for such inpatient care under the State plan;

(iv) has adequate social support services to be cared for at home; and

(v) wishes to be cared for at home.

(B) The requirements of subparagraph (A)(ii) may be satisfied by a continuous stay in one or more hospitals, nursing facilities, or intermediate care facilities for the mentally retarded.

(C) For purposes of this paragraph, respiratory care services means services provided on a part-time basis in the home of the individual by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State), payment for which is not otherwise included within other items and services furnished to such individual as medical assistance under the plan.

(10)(A) The fact that an individual, child, or pregnant woman may be denied aid under part A of title IV pursuant to section 402(a)(43) shall not be construed as denying (or permitting a State to deny) medical assistance under this title to such individual, child, or woman who is eligible for assistance under this title on a basis other than the receipt of aid under such part.

(B) If an individual, child, or pregnant woman is receiving aid under part A of title IV and such aid is terminated pursuant to section 402(a)(43), the State may not discontinue medical assistance under this title for the individual, child, or woman until the State has determined that the individual, child, or woman is not eligible for assistance under this title on a basis other than the receipt of aid under such part.

(11)(A) In the case of an individual who is enrolled with a group health plan under section 1906 and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of

this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such plan.

(B) For purposes of subparagraph (A), the term “minimum enrollment period” means, with respect to an individual’s enrollment with a group health plan, a period established by the State, of not more than 6 months beginning on the date the individual’s enrollment under the plan becomes effective.

(12) At the option of the State, the plan may provide that an individual who is under an age specified by the State (not to exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this title under subsection (a)(10)(A) shall remain eligible for those benefits until the earlier of—

(A) the end of a period (not to exceed 12 months) following the determination; or

(B) the time that the individual exceeds that age.

(13) EXPRESS LANE OPTION.—

(A) IN GENERAL.—

(i) OPTION TO USE A FINDING FROM AN EXPRESS LANE AGENCY.—At the option of the State, the State plan may provide that in determining eligibility under this title for a child (as defined in subparagraph (G)), the State may rely on a finding made within a reasonable period (as determined by the State) from an Express Lane agency (as defined in subparagraph (F)) when it determines whether a child satisfies one or more components of eligibility for medical assistance under this title. The State may rely on a finding from an Express Lane agency notwithstanding sections 1902(a)(46)(B) and 1137(d) or any differences in budget unit, disregard, deeming or other methodology, if the following requirements are met:

(I) PROHIBITION ON DETERMINING CHILDREN INELIGIBLE FOR COVERAGE.—If a finding from an Express Lane agency would result in a determination that a child does not satisfy an eligibility requirement for medical assistance under this title and for child health assistance under title XXI, the State shall determine eligibility for assistance using its regular procedures.

(II) NOTICE REQUIREMENT.—For any child who is found eligible for medical assistance under the State plan under this title or child health assistance under title XXI and who is subject to premiums based on an Express Lane agency’s finding of such child’s income level, the State shall provide notice that the child may qualify for lower premium payments if evaluated by the State using its regular policies and of the procedures for requesting such an evaluation.

(III) COMPLIANCE WITH SCREEN AND ENROLL REQUIREMENT.—The State shall satisfy the requirements under subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll) before enrolling a child in child health assistance under title XXI. At its op-

tion, the State may fulfill such requirements in accordance with either option provided under subparagraph (C) of this paragraph.

(IV) VERIFICATION OF CITIZENSHIP OR NATIONALITY STATUS.—The State shall satisfy the requirements of section 1902(a)(46)(B) or 2105(c)(9), as applicable for verifications of citizenship or nationality status.

(V) CODING.—The State meets the requirements of subparagraph (E).

(ii) OPTION TO APPLY TO RENEWALS AND REDETERMINATIONS.—The State may apply the provisions of this paragraph when conducting initial determinations of eligibility, redeterminations of eligibility, or both, as described in the State plan.

(B) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

(i) to limit or prohibit a State from taking any actions otherwise permitted under this title or title XXI in determining eligibility for or enrolling children into medical assistance under this title or child health assistance under title XXI; or

(ii) to modify the limitations in section 1902(a)(5) concerning the agencies that may make a determination of eligibility for medical assistance under this title.

(C) OPTIONS FOR SATISFYING THE SCREEN AND ENROLL REQUIREMENT.—

(i) IN GENERAL.—With respect to a child whose eligibility for medical assistance under this title or for child health assistance under title XXI has been evaluated by a State agency using an income finding from an Express Lane agency, a State may carry out its duties under subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll) in accordance with either clause (ii) or clause (iii).

(ii) ESTABLISHING A SCREENING THRESHOLD.—

(I) IN GENERAL.—Under this clause, the State establishes a screening threshold set as a percentage of the Federal poverty level that exceeds the highest income threshold applicable under this title to the child by a minimum of 30 percentage points or, at State option, a higher number of percentage points that reflects the value (as determined by the State and described in the State plan) of any differences between income methodologies used by the program administered by the Express Lane agency and the methodologies used by the State in determining eligibility for medical assistance under this title.

(II) CHILDREN WITH INCOME NOT ABOVE THRESHOLD.—If the income of a child does not exceed the screening threshold, the child is deemed to satisfy the income eligibility criteria for medical assistance under this title regardless of whether such child would otherwise satisfy such criteria.

(III) CHILDREN WITH INCOME ABOVE THRESHOLD.—If the income of a child exceeds the screening threshold, the child shall be considered to have an income above the Medicaid applicable income level described in section 2110(b)(4) and to satisfy the requirement under section 2110(b)(1)(C) (relating to the requirement that CHIP matching funds be used only for children not eligible for Medicaid). If such a child is enrolled in child health assistance under title XXI, the State shall provide the parent, guardian, or custodial relative with the following:

(aa) Notice that the child may be eligible to receive medical assistance under the State plan under this title if evaluated for such assistance under the State's regular procedures and notice of the process through which a parent, guardian, or custodial relative can request that the State evaluate the child's eligibility for medical assistance under this title using such regular procedures.

(bb) A description of differences between the medical assistance provided under this title and child health assistance under title XXI, including differences in cost-sharing requirements and covered benefits.

(iii) TEMPORARY ENROLLMENT IN CHIP PENDING SCREEN AND ENROLL.—

(I) IN GENERAL.—Under this clause, a State enrolls a child in child health assistance under title XXI for a temporary period if the child appears eligible for such assistance based on an income finding by an Express Lane agency.

(II) DETERMINATION OF ELIGIBILITY.—During such temporary enrollment period, the State shall determine the child's eligibility for child health assistance under title XXI or for medical assistance under this title in accordance with this clause.

(III) PROMPT FOLLOW UP.—In making such a determination, the State shall take prompt action to determine whether the child should be enrolled in medical assistance under this title or child health assistance under title XXI pursuant to subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll).

(IV) REQUIREMENT FOR SIMPLIFIED DETERMINATION.—In making such a determination, the State shall use procedures that, to the maximum feasible extent, reduce the burden imposed on the individual of such determination. Such procedures may not require the child's parent, guardian, or custodial relative to provide or verify information that already has been provided to the State agency by an Express Lane agency or another source of information unless the State agency has reason to believe the information is erroneous.

(V) AVAILABILITY OF CHIP MATCHING FUNDS DURING TEMPORARY ENROLLMENT PERIOD.—Medical assistance for items and services that are provided to a child enrolled in title XXI during a temporary enrollment period under this clause shall be treated as child health assistance under such title.

(D) OPTION FOR AUTOMATIC ENROLLMENT.—

(i) IN GENERAL.—The State may initiate and determine eligibility for medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan without a program application from, or on behalf of, the child based on data obtained from sources other than the child (or the child's family), but a child can only be automatically enrolled in the State Medicaid plan or the State CHIP plan if the child or the family affirmatively consents to being enrolled through affirmation in writing, by telephone, orally, through electronic signature, or through any other means specified by the Secretary or by signature on an Express Lane agency application, if the requirement of clause (ii) is met.

(ii) INFORMATION REQUIREMENT.—The requirement of this clause is that the State informs the parent, guardian, or custodial relative of the child of the services that will be covered, appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations (under section 1912(a)) created by enrollment (if applicable), and the actions the parent, guardian, or relative must take to maintain enrollment and renew coverage.

(E) CODING; APPLICATION TO ENROLLMENT ERROR RATES.—

(i) IN GENERAL.—For purposes of subparagraph (A)(iv), the requirement of this subparagraph for a State is that the State agrees to—

(I) assign such codes as the Secretary shall require to the children who are enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency for the duration of the State's election under this paragraph;

(II) annually provide the Secretary with a statistically valid sample (that is approved by Secretary) of the children enrolled in such plans through reliance on such a finding by conducting a full Medicaid eligibility review of the children identified for such sample for purposes of determining an eligibility error rate (as described in clause (iv)) with respect to the enrollment of such children (and shall not include such children in any data or samples used for purposes of complying with a Medicaid Eligibility Quality Control (MEQC) review or a payment error rate measurement (PERM) requirement);

(III) submit the error rate determined under subclause (II) to the Secretary;

(IV) if such error rate exceeds 3 percent for either of the first 2 fiscal years in which the State elects to

apply this paragraph, demonstrate to the satisfaction of the Secretary the specific corrective actions implemented by the State to improve upon such error rate; and

(V) if such error rate exceeds 3 percent for any fiscal year in which the State elects to apply this paragraph, a reduction in the amount otherwise payable to the State under section 1903(a) for quarters for that fiscal year, equal to the total amount of erroneous excess payments determined for the fiscal year only with respect to the children included in the sample for the fiscal year that are in excess of a 3 percent error rate with respect to such children.

(ii) NO PUNITIVE ACTION BASED ON ERROR RATE.—The Secretary shall not apply the error rate derived from the sample under clause (i) to the entire population of children enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency, or to the population of children enrolled in such plans on the basis of the State's regular procedures for determining eligibility, or penalize the State on the basis of such error rate in any manner other than the reduction of payments provided for under clause (i)(V).

(iii) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as relieving a State that elects to apply this paragraph from being subject to a penalty under section 1903(u), for payments made under the State Medicaid plan with respect to ineligible individuals and families that are determined to exceed the error rate permitted under that section (as determined without regard to the error rate determined under clause (i)(II)).

(iv) ERROR RATE DEFINED.—In this subparagraph, the term “error rate” means the rate of erroneous excess payments for medical assistance (as defined in section 1903(u)(1)(D)) for the period involved, except that such payments shall be limited to individuals for which eligibility determinations are made under this paragraph and except that in applying this paragraph under title XXI, there shall be substituted for references to provisions of this title corresponding provisions within title XXI.

(F) EXPRESS LANE AGENCY.—

(i) IN GENERAL.—In this paragraph, the term “Express Lane agency” means a public agency that—

(I) is determined by the State Medicaid agency or the State CHIP agency (as applicable) to be capable of making the determinations of one or more eligibility requirements described in subparagraph (A)(i);

(II) is identified in the State Medicaid plan or the State CHIP plan; and

(III) notifies the child's family—

(aa) of the information which shall be disclosed in accordance with this paragraph;

(bb) that the information disclosed will be used solely for purposes of determining eligibility for

medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan; and

(cc) that the family may elect to not have the information disclosed for such purposes; and

(IV) enters into, or is subject to, an interagency agreement to limit the disclosure and use of the information disclosed.

(ii) INCLUSION OF SPECIFIC PUBLIC AGENCIES AND INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—Such term includes the following:

(I) A public agency that determines eligibility for assistance under any of the following:

(aa) The temporary assistance for needy families program funded under part A of title IV.

(bb) A State program funded under part D of title IV.

(cc) The State Medicaid plan.

(dd) The State CHIP plan.

(ee) The Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

(ff) The Head Start Act (42 U.S.C. 9801 et seq.).

(gg) The Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.).

(hh) The Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.).

(ii) The Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.).

(jj) The Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11301 et seq.).

(kk) The United States Housing Act of 1937 (42 U.S.C. 1437 et seq.).

(ll) The Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.).

(II) A State-specified governmental agency that has fiscal liability or legal responsibility for the accuracy of the eligibility determination findings relied on by the State.

(III) A public agency that is subject to an interagency agreement limiting the disclosure and use of the information disclosed for purposes of determining eligibility under the State Medicaid plan or the State CHIP plan.

(IV) The Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in section 1139(c)).

(iii) EXCLUSIONS.—Such term does not include an agency that determines eligibility for a program established under the Social Services Block Grant established under title XX or a private, for-profit organization.

(iv) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed as—

(I) exempting a State Medicaid agency from complying with the requirements of section 1902(a)(4) relating to merit-based personnel standards for employees of the State Medicaid agency and safeguards against conflicts of interest); or

(II) authorizing a State Medicaid agency that elects to use Express Lane agencies under this subparagraph to use the Express Lane option to avoid complying with such requirements for purposes of making eligibility determinations under the State Medicaid plan.

(v) ADDITIONAL DEFINITIONS.—In this paragraph:

(I) STATE.—The term “State” means 1 of the 50 States or the District of Columbia.

(II) STATE CHIP AGENCY.—The term “State CHIP agency” means the State agency responsible for administering the State CHIP plan.

(III) STATE CHIP PLAN.—The term “State CHIP plan” means the State child health plan established under title XXI and includes any waiver of such plan.

(IV) STATE MEDICAID AGENCY.—The term “State Medicaid agency” means the State agency responsible for administering the State Medicaid plan.

(V) STATE MEDICAID PLAN.—The term “State Medicaid plan” means the State plan established under title XIX and includes any waiver of such plan.

(G) CHILD DEFINED.—For purposes of this paragraph, the term “child” means an individual under 19 years of age, or, at the option of a State, such higher age, not to exceed 21 years of age, as the State may elect.

(H) STATE OPTION TO RELY ON STATE INCOME TAX DATA OR RETURN.—At the option of the State, a finding from an Express Lane agency may include gross income or adjusted gross income shown by State income tax records or returns.

(I) APPLICATION.—This paragraph shall not apply with respect to eligibility determinations made after September 30, 2017.

(14) INCOME DETERMINED USING MODIFIED ADJUSTED GROSS INCOME.—

(A) IN GENERAL.—Notwithstanding subsection (r) or any other provision of this title, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified adjusted gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified adjusted gross income and household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on the

date of enactment of the Patient Protection and Affordable Care Act. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified adjusted gross income and household income, a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this title and title XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

(B) NO INCOME OR EXPENSE DISREGARDS.—Subject to subparagraph (I), no type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

(C) NO ASSETS TEST.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

(D) EXCEPTIONS.—

(i) INDIVIDUALS ELIGIBLE BECAUSE OF OTHER AID OR ASSISTANCE, ELDERLY INDIVIDUALS, MEDICALLY NEEDY INDIVIDUALS, AND INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING.—Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under title XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

(II) Individuals who have attained age 65.

(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and in-

cluding an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

(IV) Individuals described in subsection (a)(10)(C).

(V) Individuals described in any clause of subsection (a)(10)(E).

(ii) EXPRESS LANE AGENCY FINDINGS.—In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency in accordance with that paragraph relating to the income of an individual for purposes of determining the individual's eligibility for medical assistance under the State plan or under a waiver of the plan.

(iii) MEDICARE PRESCRIPTION DRUG SUBSIDIES DETERMINATIONS.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D–14 made by the State pursuant to section 1935(a)(2).

(iv) LONG-TERM CARE.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1915 or a waiver under section 1115, and services described in section 1917(c)(1)(C)(ii).

(v) GRANDFATHER OF CURRENT ENROLLEES UNTIL DATE OF NEXT REGULAR REDETERMINATION.—An individual who, on January 1, 2014, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified adjusted gross income or household income standard described in subparagraph (A), shall remain eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied to the individual on that date) through March 31, 2014, or the date on which the individual's next regularly scheduled redetermination of eligibility is to occur, whichever is later.

(E) TRANSITION PLANNING AND OVERSIGHT.—Each State shall submit to the Secretary for the Secretary's approval the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified adjusted gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and

procedures for purposes of making such determinations as the State used on the date of enactment of the Patient Protection and Affordable Care Act. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance.

(F) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B)) under the State plan or under a waiver of the plan and under title XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.

(G) DEFINITIONS OF MODIFIED ADJUSTED GROSS INCOME AND HOUSEHOLD INCOME.—In this paragraph, the terms “modified adjusted gross income” and “household income” have the meanings given such terms in section 36B(d)(2) of the Internal Revenue Code of 1986.

(H) CONTINUED APPLICATION OF MEDICAID RULES REGARDING POINT-IN-TIME INCOME AND SOURCES OF INCOME.—The requirement under this paragraph for States to use modified adjusted gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required shall not be construed as affecting or limiting the application of—

(i) the requirement under this title and under the State plan or a waiver of the plan to determine an individual’s income as of the point in time at which an application for medical assistance under the State plan or a waiver of the plan is processed; or

(ii) any rules established under this title or under the State plan or a waiver of the plan regarding sources of countable income.

(I) TREATMENT OF PORTION OF MODIFIED ADJUSTED GROSS INCOME.—For purposes of determining the income eligibility of an individual for medical assistance whose eligibility is determined based on the application of modified adjusted gross income under subparagraph (A), the State shall—

(i) determine the dollar equivalent of the difference between the upper income limit on eligibility for such an individual (expressed as a percentage of the pov-

erty line) and such upper income limit increased by 5 percentage points; and

(ii) notwithstanding the requirement in subparagraph (A) with respect to use of modified adjusted gross income, utilize as the applicable income of such individual, in determining such income eligibility, an amount equal to the modified adjusted gross income applicable to such individual reduced by such dollar equivalent amount.

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

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

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

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

(III) *over a period of 3 months if the amount of such winnings or income (as applicable) is greater than or equal to \$90,000 but less than \$100,000; and*

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

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

(iii) *HARDSHIP EXEMPTION.*—*An individual whose income, by application of clause (i), exceeds the applicable eligibility threshold established by the State, may continue to be eligible for medical assistance to the extent that the State determines, under procedures established by the State under the State plan (or in the case of a waiver of the plan under section 1115, incorporated in such waiver), or as otherwise established by such State in accordance with such standards as may be specified by the Secretary, that the denial of eligibility of the individual would cause an undue medical*

or financial hardship as determined on the basis of criteria established by the Secretary.

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

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

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

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

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

(K) **FREQUENCY OF ELIGIBILITY REDETERMINATIONS.**—Beginning on October 1, 2017, and notwithstanding subparagraph (H), in the case of an individual whose eligibility for medical assistance under the State plan under this title (or a waiver of such plan) is determined based on the application of modified adjusted gross income under subparagraph (A) and who is so eligible on the basis of clause (i)(VIII) or clause (ii)(XX) of subsection (a)(10)(A), a State shall redetermine such individual’s eligibility for such medical assistance no less frequently than once every 6 months.

[(14)] (15) EXCLUSION OF COMPENSATION FOR PARTICIPATION IN A CLINICAL TRIAL FOR TESTING OF TREATMENTS FOR A RARE DISEASE OR CONDITION.—The first \$2,000 received by an individual (who has attained 19 years of age) as compensation for participation in a clinical trial meeting the requirements of section 1612(b)(26) shall be disregarded for purposes of determining the income eligibility of such individual for medical assistance under the State plan or any waiver of such plan.

(f) Notwithstanding any other provision of this title, except as provided in subsection (e) and section 1619(b)(3) and section 1924, except with respect to qualified disabled and working individuals (described in section 1905(s)), and except with respect to qualified

medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1), no State not eligible to participate in the State plan program established under title XVI shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in title XVI, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

(g) In addition to any other sanction available to a State, a State may provide for a reduction of any payment amount otherwise due with respect to a person who furnishes services under the plan in an amount equal to up to three times the amount of any payment sought to be collected by that person in violation of subsection (a)(25)(C).

(h) Nothing in this title (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment that may be made under a plan under this title for home and community care.

(i)(1) In addition to any other authority under State law, where a State determines that a intermediate care facility for the men-

tally retarded which is certified for participation under its plan no longer substantially meets the requirements for such a facility under this title and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, establish alternative remedies if the State demonstrates to the Secretary's satisfaction that the alternative remedies are effective in deterring noncompliance and correcting deficiencies, and may provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the requirements for such a facility under this title, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the requirements for such a facility under this title, or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.

(j) Notwithstanding any other requirement of this title, the Secretary may waive or modify any requirement of this title with respect to the medical assistance program in American Samoa and the Northern Mariana Islands, other than a waiver of the Federal medical assistance percentage, the limitation in section 1108(f), or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa or the Northern Mariana Islands for care and services described in a numbered paragraph of section 1905(a).

(k)(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of section 1937, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section,

unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1937(a)(2), the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1937 or benchmark equivalent coverage described in subsection (b)(2) of that section.

(2) Beginning with the first day of any fiscal year quarter that begins on or after April 1, 2010, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2), the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term "parent" includes an individual treated as a caretaker relative for purposes of carrying out section 1931.

(1)(1) Individuals described in this paragraph are—

(A) women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy),

(B) infants under one year of age,

(C) children who have attained one year of age but have not attained 6 years of age, and

(D) children born after September 30, 1983 (or, at the option of a State, after any earlier date), who have attained 6 years of age but have not attained 19 years of age,

who are not described in any of subclauses (I) through (III) of subsection (a)(10)(A)(i) and whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

(2)(A)(i) For purposes of paragraph (1) with respect to individuals described in subparagraph (A) or (B) of that paragraph, the State shall establish an income level which is a percentage (not less than the percentage provided under clause (ii) and not more than 185 percent) of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(ii) The percentage provided under this clause, with respect to eligibility for medical assistance on or after—

(I) July 1, 1989, is 75 percent, or, if greater, the percentage provided under clause (iii), and

(II) April 1, 1990, 133 percent, or, if greater, the percentage provided under clause (iv).

(iii) In the case of a State which, as of the date of the enactment of this clause, has elected to provide, and provides, medical assistance to individuals described in this subsection or has enacted legislation authorizing, or appropriating funds, to provide such assistance to such individuals before July 1, 1989, the percentage provided under clause (ii)(I) shall not be less than—

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of the date of the enactment of this clause, or

(II) if no such percentage is specified as of the date of the enactment of this clause, the percentage established under the State's authorizing legislation or provided for under the State's appropriations;

but in no case shall this clause require the percentage provided under clause (ii)(I) to exceed 100 percent.

(iv) In the case of a State which, as of the date of the enactment of this clause, has established under clause (i), or has enacted legislation authorizing, or appropriating funds, to provide for, a percentage (of the income official poverty line) that is greater than 133 percent, the percentage provided under clause (ii) for medical assistance on or after April 1, 1990, shall not be less than—

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of the date of the enactment of this clause, or

(II) if no such percentage is specified as of the date of the enactment of this clause, the percentage established under the State's authorizing legislation or provided for under the State's appropriations.

(B) For purposes of paragraph (1) with respect to individuals described in subparagraph (C) of such paragraph, the State shall establish an income level which is equal to 133 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(C) For purposes of paragraph (1) with respect to individuals described in subparagraph (D) of that paragraph, the State shall establish an income level which is equal to 100 percent (or, beginning January 1, 2014, *and ending December 31, 2019*, 133 percent) of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(3) Notwithstanding subsection (a)(17), for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)—

(A) application of a resource standard shall be at the option of the State;

(B) any resource standard or methodology that is applied with respect to an individual described in subparagraph (A) of paragraph (1) may not be more restrictive than the resource standard or methodology that is applied under title XVI;

(C) any resource standard or methodology that is applied with respect to an individual described in subparagraph (B), (C), or (D) of paragraph (1) may not be more restrictive than

the corresponding methodology that is applied under the State plan under part A of title IV;

(D) the income standard to be applied is the appropriate income standard established under paragraph (2); and

(E) family income shall be determined in accordance with the methodology employed under the State plan under part A or E of title IV (except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17)), and costs incurred for medical care or for any other type of remedial care shall not be taken into account.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(4)(A) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) and for children described in subsection (a)(10)(A)(i)(VI) or subsection (a)(10)(A)(i)(VII) in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this title.

(B) In the case of a State which is not one of the 50 States or the District of Columbia, the State need not meet the requirement of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), or (a)(10)(A)(i)(VII) and, for purposes of paragraph (2)(A), the State may substitute for the percentage provided under clause (ii) of such paragraph any percentage.

(m)(1) Individuals described in this paragraph are individuals—

(A) who are 65 years of age or older or are disabled individuals (as determined under section 1614(a)(3)),

(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in paragraph (2)(C)) does not exceed an income level established by the State consistent with paragraph (2)(A), and

(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.

(2)(A) The income level established under paragraph (1)(B) may not exceed a percentage (not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(B) In the case of a State that provides medical assistance to individuals not described in subsection (a)(10)(A) and at the State's option, the State may use under paragraph (1)(C) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in subsection (a)(10)(A).

(C) The provisions of section 1905(p)(2)(D) shall apply to determinations of income under this subsection in the same manner as they apply to determinations of income under section 1905(p).

(3) Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(X)—

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(4) Notwithstanding subsection (a)(17), for qualified medicare beneficiaries described in section 1905(p)(1)—

(A) the income standard to be applied is the income standard described in section 1905(p)(1)(B), and

(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(n)(1) In the case of medical assistance furnished under this title for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under title XVIII with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.

(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—

(A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and

(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or

title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

(o) Notwithstanding any provision of subsection (a) to the contrary, a State plan under this title shall provide that any supplemental security income benefits paid by reason of subparagraph (E) or (G) of section 1611(e)(1) to an individual who—

(1) is eligible for medical assistance under the plan, and

(2) is in a hospital, skilled nursing facility, or intermediate care facility at the time such benefits are paid, will be disregarded for purposes of determining the amount of any post-eligibility contribution by the individual to the cost of the care and services provided by the hospital, skilled nursing facility, or intermediate care facility.

(p)(1) In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this title for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII under section 1128, 1128A, or 1866(b)(2).

(2) In order for a State to receive payments for medical assistance under section 1903(a), with respect to payments the State makes to a medicaid managed care organization (as defined in section 1903(m)) or to an entity furnishing services under a waiver approved under section 1915(b)(1), the State must provide that it will exclude from participation, as such an organization or entity, any organization or entity that—

(A) could be excluded under section 1128(b)(8) (relating to owners and managing employees who have been convicted of certain crimes or received other sanctions),

(B) has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B), or

(C) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.

(3) As used in this subsection, the term “exclude” includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.

(q)(1)(A) In order to meet the requirement of subsection (a)(50), the State plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual’s or couple’s income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the State plan) a monthly personal needs allowance—

(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in paragraph (2).

(B) In this subsection, the term “institutionalized individual or couple” means an individual or married couple—

(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this title throughout a month, and

(ii) who is or are determined to be eligible for medical assistance under the State plan.

(2) The minimum monthly personal needs allowance described in this paragraph is \$30 for an institutionalized individual and \$60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

(r)(1)(A) For purposes of sections 1902(a)(17) and 1924(d)(1)(D) and for purposes of a waiver under section 1915, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, the treatment described in subparagraph (B) shall apply, there shall be disregarded reparation payments made by the Federal Republic of Germany, and there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) medicare and other health insurance premiums, deductibles, or coinsurance, and

(ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this title, subject to reasonable limits the State may establish on the amount of these expenses.

(B)(i) In the case of a veteran who does not have a spouse or a child, if the veteran—

(I) receives, after the veteran has been determined to be eligible for medical assistance under the State plan under this title, a veteran’s pension in excess of \$90 per month, and

(II) resides in a State veterans home with respect to which the Secretary of Veterans Affairs makes per diem payments for nursing home care pursuant to section 1741(a) of title 38, United States Code,

any such pension payment, including any payment made due to the need for aid and attendance, or for unreimbursed medical expenses, that is in excess of \$90 per month shall be counted as income only for the purpose of applying such excess payment to the State veterans home’s cost of providing nursing home care to the veteran.

(ii) The provisions of clause (i) shall apply with respect to a surviving spouse of a veteran who does not have a child in the same manner as they apply to a veteran described in such clause.

(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) or under section 1905(p) may

be less restrictive, and shall be no more restrictive, than the methodology—

(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI, or

(ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be “no more restrictive” if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

(s) In order to meet the requirements of subsection (a)(55), the State plan must provide that payments to hospitals under the plan for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital described in section 1923(b)(1), shall—

(1) if made on a prospective basis (whether per diem, per case, or otherwise) provide for an outlier adjustment in payment amounts for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay,

(2) not be limited by the imposition of day limits with respect to the delivery of such services to such individuals, and

(3) not be limited by the imposition of dollar limits (other than such limits resulting from prospective payments as adjusted pursuant to paragraph (1)) with respect to the delivery of such services to any such individual who has not attained their first birthday (or in the case of such an individual who is an inpatient on his first birthday until such individual is discharged).

(t) Nothing in this title (including sections 1903(a) and 1905(a)) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes of general applicability imposed with respect to the provision of such items or services.

(u)(1) Individuals described in this paragraph are individuals—

(A) who are entitled to elect COBRA continuation coverage (as defined in paragraph (3)),

(B) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program, and

(D) with respect to whose enrollment for COBRA continuation coverage the State has determined that the savings in expenditures under this title resulting from such enrollment is

likely to exceed the amount of payments for COBRA premiums made.

(2) For purposes of subsection (a)(10)(F) and this subsection, the term “COBRA premiums” means the applicable premium imposed with respect to COBRA continuation coverage.

(3) In this subsection, the term “COBRA continuation coverage” means coverage under a group health plan provided by an employer with 75 or more employees provided pursuant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974.

(4) Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(XI)—

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(10)(B) or (a)(17), require or permit such treatment for other individuals.

(v) A State plan may provide for the making of determinations of disability or blindness for the purpose of determining eligibility for medical assistance under the State plan by the single State agency or its designee, and make medical assistance available to individuals whom it finds to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the Social Security Administration with respect to such an individual. In making such determinations, the State must apply the definitions of disability and blindness found in section 1614(a) of the Social Security Act.

(w)(1) For purposes of subsection (a)(57) and sections 1903(m)(1)(A) and 1919(c)(2)(E), the requirement of this subsection is that a provider or organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) to provide written information to each such individual concerning—

(i) an individual’s rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the provider’s or organization’s written policies respecting the implementation of such rights;

(B) to document in the individual’s medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a provider of home health care or personal care services, in advance of the individual coming under the care of the provider,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of a medicaid managed care organization, at the time of enrollment of the individual with the organization.

(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

(4) In this subsection, the term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(5) For construction relating to this subsection, see section 7 of the Assisted Suicide Funding Restriction Act of 1997 (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).

(x) The Secretary shall establish a system, for implementation by not later than July 1, 1991, which provides for a unique identifier for each physician who furnishes services for which payment may be made under a State plan approved under this title.

(y)(1) In addition to any other authority under State law, where a State determines that a psychiatric hospital which is certified for participation under its plan no longer meets the requirements for a psychiatric hospital (referred to in section 1905(h)) and further finds that the hospital's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall terminate the hospital's participation under the State plan; or

(B) do not immediately jeopardize the health and safety of its patients, the State may terminate the hospital's participation under the State plan, or provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) Except as provided in paragraph (3), if a psychiatric hospital described in paragraph (1)(B) has not complied with the requirements for a psychiatric hospital under this title—

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no Federal financial participation shall be provided under section 1903(a) with respect to further services provided in the hospital until the State finds that the hospital is in compliance with the requirements of this title.

(3) The Secretary may continue payments, over a period of not longer than 6 months from the date the hospital is found to be out of compliance with such requirements, if—

(A) the State finds that it is more appropriate to take alternative action to assure compliance of the hospital with the requirements than to terminate the certification of the hospital,

(B) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(C) the State agrees to repay to the Federal Government payments received under this paragraph if the corrective action is not taken in accordance with the approved plan and timetable.

(z)(1) Individuals described in this paragraph are individuals not described in subsection (a)(10)(A)(i)—

(A) who are infected with tuberculosis;

(B) whose income (as determined under the State plan under this title with respect to disabled individuals) does not exceed the maximum amount of income a disabled individual described in subsection (a)(10)(A)(i) may have and obtain medical assistance under the plan; and

(C) whose resources (as determined under the State plan under this title with respect to disabled individuals) do not exceed the maximum amount of resources a disabled individual described in subsection (a)(10)(A)(i) may have and obtain medical assistance under the plan.

(2) For purposes of subsection (a)(10), the term “TB-related services” means each of the following services relating to treatment of infection with tuberculosis:

(A) Prescribed drugs.

(B) Physicians’ services and services described in section 1905(a)(2).

(C) Laboratory and X-ray services (including services to confirm the presence of infection).

(D) Clinic services and Federally-qualified health center services.

(E) Case management services (as defined in section 1915(g)(2)).

(F) Services (other than room and board) designed to encourage completion of regimens of prescribed drugs by outpatients,

including services to observe directly the intake of prescribed drugs.

(aa) Individuals described in this subsection are individuals who—

- (1) are not described in subsection (a)(10)(A)(i);
- (2) have not attained age 65;
- (3) have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention breast and cervical cancer early detection program established under title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) in accordance with the requirements of section 1504 of that Act (42 U.S.C. 300n) and need treatment for breast or cervical cancer; and
- (4) are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)), but applied without regard to paragraph (1)(F) of such section.

(bb) PAYMENT FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—

(1) IN GENERAL.—Beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by a Federally-qualified health center and services described in section 1905(a)(2)(B) furnished by a rural health clinic in accordance with the provisions of this subsection.

(2) FISCAL YEAR 2001.—Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

(3) FISCAL YEAR 2002 AND SUCCEEDING FISCAL YEARS.—Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

(A) increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year; and

(B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.

(4) ESTABLISHMENT OF INITIAL YEAR PAYMENT AMOUNT FOR NEW CENTERS OR CLINICS.—In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by the center or services described in section 1905(a)(2)(B) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

(5) ADMINISTRATION IN THE CASE OF MANAGED CARE.—

(A) IN GENERAL.—In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1932(a)(1)(B)), the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

(B) PAYMENT SCHEDULE.—The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the Federally-qualified health center or rural health clinic, but in no case less frequently than every 4 months.

(6) ALTERNATIVE PAYMENT METHODOLOGIES.—Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1905(a)(2)(C) or to a rural health clinic for services described in section 1905(a)(2)(B) in an amount which is determined under an alternative payment methodology that—

(A) is agreed to by the State and the center or clinic; and

(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.

(cc)(1) Individuals described in this paragraph are individuals—

(A) who are children who have not attained 19 years of age and are born—

(i) on or after January 1, 2001 (or, at the option of a State, on or after an earlier date), in the case of the second, third, and fourth quarters of fiscal year 2007;

(ii) on or after October 1, 1995 (or, at the option of a State, on or after an earlier date), in the case of each quarter of fiscal year 2008; and

(iii) after October 1, 1989, in the case of each quarter of fiscal year 2009 and each quarter of any fiscal year thereafter;

(B) who would be considered disabled under section 1614(a)(3)(C) (as determined under title XVI for children but without regard to any income or asset eligibility requirements that apply under such title with respect to children); and

(C) whose family income does not exceed such income level as the State establishes and does not exceed—

(i) 300 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved; or

(ii) such higher percent of such poverty line as a State may establish, except that—

(I) any medical assistance provided to an individual whose family income exceeds 300 percent of such poverty line may only be provided with State funds; and

(II) no Federal financial participation shall be provided under section 1903(a) for any medical assistance provided to such an individual.

(2)(A) If an employer of a parent of an individual described in paragraph (1) offers family coverage under a group health plan (as defined in section 2791(a) of the Public Health Service Act), the State shall—

(i) notwithstanding section 1906, require such parent to apply for, enroll in, and pay premiums for such coverage as a condition of such parent's child being or remaining eligible for medical assistance under subsection (a)(10)(A)(ii)(XIX) if the parent is determined eligible for such coverage and the employer contributes at least 50 percent of the total cost of annual premiums for such coverage; and

(ii) if such coverage is obtained—

(I) subject to paragraph (2) of section 1916(h), reduce the premium imposed by the State under that section in an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability; and

(II) treat such coverage as a third party liability under subsection (a)(25).

(B) In the case of a parent to which subparagraph (A) applies, a State, notwithstanding section 1906 but subject to paragraph (1)(C)(ii), may provide for payment of any portion of the annual premium for such family coverage that the parent is required to pay. Any payments made by the State under this subparagraph shall be considered, for purposes of section 1903(a), to be payments for medical assistance.

(dd) ELECTRONIC TRANSMISSION OF INFORMATION.—If the State agency determining eligibility for medical assistance under this title or child health assistance under title XXI verifies an element of eligibility based on information from an Express Lane Agency (as defined in subsection (e)(13)(F)), or from another public agency, then the applicant's signature under penalty of perjury shall not be

required as to such element. Any signature requirement for an application for medical assistance may be satisfied through an electronic signature, as defined in section 1710(1) of the Government Paperwork Elimination Act (44 U.S.C. 3504 note). The requirements of subparagraphs (A) and (B) of section 1137(d)(2) may be met through evidence in digital or electronic form.

(ee)(1) For purposes of subsection (a)(46)(B)(ii), the requirements of this subsection with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this title, are, in lieu of requiring the individual to present satisfactory documentary evidence of citizenship or nationality under section 1903(x) (if the individual is not described in paragraph (2) of that section), as follows:

(A) The State submits the name and social security number of the individual to the Commissioner of Social Security as part of the program established under paragraph (2).

(B) If the State receives notice from the Commissioner of Social Security that the name or social security number, or the declaration of citizenship or nationality, of the individual is inconsistent with information in the records maintained by the Commissioner—

(i) the State makes a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the individual to confirm the accuracy of the name or social security number submitted or declaration of citizenship or nationality and by taking such additional actions as the Secretary, through regulation or other guidance, or the State may identify, and continues to provide the individual with medical assistance while making such effort; and

(ii) in the case such inconsistency is not resolved under clause (i), the State—

(I) notifies the individual of such fact;

(II) provides the individual with a period of 90 days from the date on which the notice required under subclause (I) is received by the individual to either present satisfactory documentary evidence of citizenship or nationality (as defined in section 1903(x)(3)) or resolve the inconsistency with the Commissioner of Social Security (and continues to provide the individual with medical assistance during such 90-day period); and

(III) disenrolls the individual from the State plan under this title within 30 days after the end of such 90-day period if no such documentary evidence is presented or if such inconsistency is not resolved.

(2)(A) Each State electing to satisfy the requirements of this subsection for purposes of section 1902(a)(46)(B) shall establish a program under which the State submits at least monthly to the Commissioner of Social Security for comparison of the name and social security number, of each individual newly enrolled in the State plan under this title that month who is not described in section 1903(x)(2) and who declares to be a United States citizen or na-

tional, with information in records maintained by the Commissioner.

(B) In establishing the State program under this paragraph, the State may enter into an agreement with the Commissioner of Social Security—

(i) to provide, through an on-line system or otherwise, for the electronic submission of, and response to, the information submitted under subparagraph (A) for an individual enrolled in the State plan under this title who declares to be citizen or national on at least a monthly basis; or

(ii) to provide for a determination of the consistency of the information submitted with the information maintained in the records of the Commissioner through such other method as agreed to by the State and the Commissioner and approved by the Secretary, provided that such method is no more burdensome for individuals to comply with than any burdens that may apply under a method described in clause (i).

(C) The program established under this paragraph shall provide that, in the case of any individual who is required to submit a social security number to the State under subparagraph (A) and who is unable to provide the State with such number, shall be provided with at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality (as defined in section 1903(x)(3)) as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.

(3)(A) The State agency implementing the plan approved under this title shall, at such times and in such form as the Secretary may specify, provide information on the percentage each month that the inconsistent submissions bears to the total submissions made for comparison for such month. For purposes of this subparagraph, a name, social security number, or declaration of citizenship or nationality of an individual shall be treated as inconsistent and included in the determination of such percentage only if—

(i) the information submitted by the individual is not consistent with information in records maintained by the Commissioner of Social Security;

(ii) the inconsistency is not resolved by the State;

(iii) the individual was provided with a reasonable period of time to resolve the inconsistency with the Commissioner of Social Security or provide satisfactory documentation of citizenship status and did not successfully resolve such inconsistency; and

(iv) payment has been made for an item or service furnished to the individual under this title.

(B) If, for any fiscal year, the average monthly percentage determined under subparagraph (A) is greater than 3 percent—

(i) the State shall develop and adopt a corrective plan to review its procedures for verifying the identities of individuals seeking to enroll in the State plan under this title and to identify and implement changes in such procedures to improve their accuracy; and

(ii) pay to the Secretary an amount equal to the amount which bears the same ratio to the total payments under the

State plan for the fiscal year for providing medical assistance to individuals who provided inconsistent information as the number of individuals with inconsistent information in excess of 3 percent of such total submitted bears to the total number of individuals with inconsistent information.

(C) The Secretary may waive, in certain limited cases, all or part of the payment under subparagraph (B)(ii) if the State is unable to reach the allowable error rate despite a good faith effort by such State.

(D) Subparagraphs (A) and (B) shall not apply to a State for a fiscal year if there is an agreement described in paragraph (2)(B) in effect as of the close of the fiscal year that provides for the submission on a real-time basis of the information described in such paragraph.

(4) Nothing in this subsection shall affect the rights of any individual under this title to appeal any disenrollment from a State plan.

(ff) Notwithstanding any other requirement of this title or any other provision of Federal or State law, a State shall disregard the following property from resources for purposes of determining the eligibility of an individual who is an Indian for medical assistance under this title:

(1) Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.

(2) For any federally recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.

(3) Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

(4) Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

(gg) MAINTENANCE OF EFFORT.—

(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS FULLY OPERATIONAL.—Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quar-

ters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

(4) DETERMINATION OF COMPLIANCE.—

(A) STATES SHALL APPLY MODIFIED ADJUSTED GROSS INCOME.—A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who,

on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

(hh)(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

(2) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term "parent" includes an individual treated as a caretaker relative for purposes of carrying out section 1931.

(ii)(1) Individuals described in this subsection are individuals—

(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

(B) who are not pregnant.

(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XVI) of the matter following subparagraph (G) of section subsection (a)(10) pursuant to a waiver granted under section 1115.

(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.

(jj) PRIMARY CARE SERVICES DEFINED.—For purposes of subsection (a)(13)(C), the term "primary care services" means—

(1) evaluation and management services that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the

Healthcare Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified); and

(2) services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such System.

(kk) PROVIDER AND SUPPLIER SCREENING, OVERSIGHT, AND REPORTING REQUIREMENTS.—For purposes of subsection (a)(77), the requirements of this subsection are the following:

(1) SCREENING.—The State complies with the process for screening providers and suppliers under this title, as established by the Secretary under section 1866(j)(2).

(2) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS AND SUPPLIERS.—The State complies with procedures to provide for a provisional period of enhanced oversight for new providers and suppliers under this title, as established by the Secretary under section 1866(j)(3).

(3) DISCLOSURE REQUIREMENTS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to comply with the disclosure requirements established by the Secretary under section 1866(j)(5).

(4) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS.—

(A) TEMPORARY MORATORIUM IMPOSED BY THE SECRETARY.—

(i) IN GENERAL.—Subject to clause (ii), the State complies with any temporary moratorium on the enrollment of new providers or suppliers imposed by the Secretary under section 1866(j)(7).

(ii) EXCEPTIONS.—

(I) COMPLIANCE WITH MORATORIUM.—A State shall not be required to comply with a temporary moratorium described in clause (i) if the State determines that the imposition of such temporary moratorium would adversely impact beneficiaries' access to medical assistance.

(II) FFP AVAILABLE.—Notwithstanding section 1903(i)(2)(E), payment may be made to a State under this title with respect to amounts expended for items and services described in such section if the Secretary, in consultation with the State agency administering the State plan under this title (or a waiver of the plan), determines that denying payment to the State pursuant to such section would adversely impact beneficiaries' access to medical assistance.

(iii) LIMITATION ON CHARGES TO BENEFICIARIES.—With respect to any amount expended for items or services furnished during calendar quarters beginning on or after October 1, 2017, the State prohibits, during the period of a temporary moratorium described in clause (i), a provider meeting the requirements specified in subparagraph (C)(iii) of section 1866(j)(7) from

charging an individual or other person eligible to receive medical assistance under the State plan under this title (or a waiver of the plan) for an item or service described in section 1903(i)(2)(E) furnished to such an individual.

(B) MORATORIUM ON ENROLLMENT OF PROVIDERS AND SUPPLIERS.—At the option of the State, the State imposes, for purposes of entering into participation agreements with providers or suppliers under the State plan or under a waiver of the plan, periods of enrollment moratoria, or numerical caps or other limits, for providers or suppliers identified by the Secretary as being at high-risk for fraud, waste, or abuse as necessary to combat fraud, waste, or abuse, but only if the State determines that the imposition of any such period, cap, or other limits would not adversely impact beneficiaries' access to medical assistance.

(5) COMPLIANCE PROGRAMS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to establish, in accordance with the requirements of section 1866(j)(7), a compliance program that contains the core elements established under subparagraph (B) of that section 1866(j)(7) for providers or suppliers within a particular industry or category.

(6) REPORTING OF ADVERSE PROVIDER ACTIONS.—The State complies with the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, in accordance with regulations of the Secretary.

(7) ENROLLMENT AND NPI OF ORDERING OR REFERRING PROVIDERS.—The State requires—

(A) all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the plan as a participating provider; and

(B) the national provider identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

(8) PROVIDER TERMINATIONS.—

(A) IN GENERAL.—Beginning on July 1, 2018, in the case of a notification under subsection (a)(41) with respect to a termination for a reason specified in section 455.101 of title 42, Code of Federal Regulations (as in effect on November 1, 2015) or for any other reason specified by the Secretary, of the participation of a provider of services or any other person under the State plan (or under a waiver of the plan), the State, not later than 30 days after the effective date of such termination, submits to the Secretary with respect to any such provider or person, as appropriate—

- (i) the name of such provider or person;
- (ii) the provider type of such provider or person;
- (iii) the specialty of such provider's or person's practice;

(iv) the date of birth, Social Security number, national provider identifier (if applicable), Federal taxpayer identification number, and the State license or certification number of such provider or person (if applicable);

(v) the reason for the termination;

(vi) a copy of the notice of termination sent to the provider or person;

(vii) the date on which such termination is effective, as specified in the notice; and

(viii) any other information required by the Secretary.

(B) EFFECTIVE DATE DEFINED.—For purposes of this paragraph, the term “effective date” means, with respect to a termination described in subparagraph (A), the later of—

(i) the date on which such termination is effective, as specified in the notice of such termination; or

(ii) the date on which all appeal rights applicable to such termination have been exhausted or the timeline for any such appeal has expired.

(9) OTHER STATE OVERSIGHT.—Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider and supplier screening or enhanced provider and supplier oversight activities beyond those required by the Secretary.

(II) TERMINATION NOTIFICATION DATABASE.—In the case of a provider of services or any other person whose participation under this title or title XXI is terminated (as described in subsection (kk)(8)), the Secretary shall, not later than 30 days after the date on which the Secretary is notified of such termination under subsection (a)(41) (as applicable), review such termination and, if the Secretary determines appropriate, include such termination in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 1395cc note; Public Law 111–148).

(mm) DIRECTORY PHYSICIAN OR PROVIDER DESCRIBED.—A physician or provider described in this subsection is—

(1) in the case of a physician or provider of a provider type for which the State agency, as a condition on receiving payment for items and services furnished by the physician or provider to individuals eligible to receive medical assistance under the State plan, requires the enrollment of the physician or provider with the State agency, a physician or a provider that—

(A) is enrolled with the agency as of the date on which the directory is published or updated (as applicable) under subsection (a)(83); and

(B) received payment under the State plan in the 12-month period preceding such date; and

(2) in the case of a physician or provider of a provider type for which the State agency does not require such enrollment, a physician or provider that received payment under the State plan (or a waiver of the plan) in the 12-month period preceding the date on which the directory is published or updated (as applicable) under subsection (a)(83).

PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section *and section 1903A(a)*) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) and (j) of this section and subsection 1923(f)) of the total amount expended during such quarter as medical assistance under the State plan; plus

(2)(A) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency; plus

(B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) (including the costs for nurse aides to complete such competency evaluation programs), regardless of whether the programs are provided in or outside nursing facilities or of the skill of the personnel involved in such programs, an amount equal to 50 percent (or, for calendar quarters beginning on or after July 1, 1988, and before October 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such programs; plus

(C) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to preadmission screening and resident review activities conducted by the State under section 1919(e)(7); plus

(D) for each calendar quarter during—

- (i) fiscal year 1991, an amount equal to 90 percent,
- (ii) fiscal year 1992, an amount equal to 85 percent,
- (iii) fiscal year 1993, an amount equal to 80 percent, and
- (iv) fiscal year 1994 and thereafter, an amount equal to 75 percent,

of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to State activities under section 1919(g); plus

(E) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to translation or interpretation serv-

ices in connection with the enrollment of, retention of, and use of services under this title by, children of families for whom English is not the primary language; plus

(3) an amount equal to—

(A)(i) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title,

(ii) 90 per centum of so much of the sums expended during any such quarter in the fiscal year ending June 30, 1972, or the fiscal year ending June 30, 1973, as are attributable to the design, development, or installation of cost determination systems for State-owned general hospitals (except that the total amount paid to all States under this clause for either such fiscal year shall not exceed \$150,000), and

(iii) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such developments or modifications of systems of the type described in clause (i) as are necessary for the efficient collection and reporting on child health measures; and

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; and

(C)(i) 75 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of medical and utilization review by a utilization and quality control peer review organization or by an entity

which meets the requirements of section 1152, as determined by the Secretary, under a contract entered into under section 1902(d); and

(ii) 75 percent of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of independent external reviews conducted under section 1932(c)(2); and

(D) 75 percent of so much of the sums expended by the State plan during a quarter in 1991, 1992, or 1993, as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of section 1927(g);

(E) 50 percent of the sums expended with respect to costs incurred during such quarter as are attributable to providing—

(i) services to identify and educate individuals who are likely to be eligible for medical assistance under this title and who have Sickle Cell Disease or who are carriers of the sickle cell gene, including education regarding how to identify such individuals; or

(ii) education regarding the risks of stroke and other complications, as well as the prevention of stroke and other complications, in individuals who are likely to be eligible for medical assistance under this title and who have Sickle Cell Disease; and

(F)(i) 100 percent of so much of the sums expended during such quarter as are attributable to payments to Medicaid providers described in subsection (t)(1) to encourage the adoption and use of certified EHR technology; and

(ii) 90 percent of so much of the sums expended during such quarter as are attributable to payments for reasonable administrative expenses related to the administration of payments described in clause (i) if the State meets the condition described in subsection (t)(9); plus

(H)(i) 90 percent of the sums expended during the quarter as are attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement section 1902(ee) (including a system described in paragraph (2)(B) thereof), and

(ii) 75 percent of the sums expended during the quarter as are attributable to the operation of systems to which clause (i) applies, plus

(4) an amount equal to 100 percent of the sums expended during the quarter which are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus

(5) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies;

(6) subject to subsection (b)(3), an amount equal to—

(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

(B) 75 per centum of the sums expended during each succeeding calendar quarter, with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q)); plus

(7) subject to section 1919(g)(3)(B), an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b)(1) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter beginning after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under title XVIII which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of title XVIII, other than amounts expended under provisions of the plan of such State required by section 1902(a)(34).

(2) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(6) may not exceed the higher of—

(A) \$125,000, or

(B) one-quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this title.

(4) Amounts expended by a State for the use of an enrollment broker in marketing medicaid managed care organizations and other managed care entities to eligible individuals under this title shall be considered, for purposes of subsection (a)(7), to be necessary for the proper and efficient administration of the State plan but only if the following conditions are met with respect to the broker:

(A) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this title) that provide coverage of services in the same State in which the broker is conducting enrollment activities.

(B) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under

this title or title XVIII or debarred by any Federal agency, or subject to a civil money penalty under this Act.

(5) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State shall be decreased in a quarter by the amount of any health care related taxes (described in section 1902(w)(3)(A)) that are imposed on a hospital described in subsection (w)(3)(F) in that quarter.

(c) Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of such Act.

(d)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount ~~【to which】~~ *to which, subject to section 1903A(a)*, a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2)(A) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(B) Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1902(a)(25).

(C) For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 1 year in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 1-year period, whether or not recovery was made.

(D)(i) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).

(ii) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3)(A) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(B)(i) Subparagraph (A) and paragraph (2)(B) shall not apply to any amount recovered or paid to a State as part of the comprehensive settlement of November 1998 between manufacturers of tobacco products, as defined in section 5702(d) of the Internal Revenue Code of 1986, and State Attorneys General, or as part of any individual State settlement or judgment reached in litigation initiated or pursued by a State against one or more such manufacturers.

(ii) Except as provided in subsection (i)(19), a State may use amounts recovered or paid to the State as part of a comprehensive or individual settlement, or a judgment, described in clause (i) for any expenditures determined appropriate by the State.

(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1116(d), and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this title, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates during such period.

(6)(A) Each State (as defined in subsection (w)(7)(D)) shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to—

(i) provider-related donations made to the State or units of local government during such fiscal year, and

(ii) health care related taxes collected by the State or such units during such fiscal year.

(B) Each State shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to the total amount of payment adjustments made, and the amount of payment adjustments made to individual providers (by provider), under section 1923(c) during such fiscal year.

(e) A State plan approved under this title may include, as a cost with respect to hospital services under the plan under this title, periodic expenditures made to reflect transitional allowances established with respect to a hospital closure or conversion under section 1884.

(f)(1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133 $\frac{1}{3}$ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act.

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of \$100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of \$100 or such other amount, as the case may be.

(2)(A) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred by such family for medical care or for any other type of remedial care recognized under State law or, (B) notwithstanding section 1916 at State option, an amount paid by such family, at the family's option, to the State, provided that the amount, when combined with costs incurred in prior months, is sufficient when excluded from the family's income to reduce such family's income below the applicable income limitation described in paragraph (1). The amount of State expenditures for which medical assistance is available under subsection (a)(1) will be reduced by amounts paid to the State pursuant to this subparagraph.

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of title IV of this Act shall be the amount determined

by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan provided for aid to such a family.

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual described in section 1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(V), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), 1902(a)(10)(A)(i)(VIII), 1902(a)(10)(A)(i)(IX), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(A)(ii)(XIII), 1902(a)(10)(A)(ii)(XIV), or 1902(a)(10)(A)(ii)(XV), 1902(a)(10)(A)(ii)(XVI), 1902(a)(10)(A)(ii)(XVII), 1902(a)(10)(A)(ii)(XVIII), 1902(a)(10)(A)(ii)(XIX), 1902(a)(10)(A)(ii)(XX), 1902(a)(10)(A)(ii)(XXI), 1902(a)(10)(A)(ii)(XXII), 1905(p)(1) or for any individual—

(A) who is receiving aid or assistance under any plan of the State approved under title I, X, XIV or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), or who is a PACE program eligible individual enrolled in a PACE program under section 1934, but only if the income of such individual (as determined under section 1612, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1),

at the time of the provision of the medical assistance giving rise to such expenditure.

(g)(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876 or which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or services in an intermediate care facility for the mentally retarded for 60 days or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such

care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services or services in an intermediate care facility for the mentally retarded furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals and intermediate care facilities for the mentally retarded pursuant to paragraphs (26) and (31) of section 1902(a) whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1812.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct timely sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this title, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(3)(A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—

(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

(ii) before January 1, 1978;

(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before January 1, 1978, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to any calendar quarter ending on or before December 31, 1978, is satisfactory under such paragraph and is valid under paragraph (2).

(4)(A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfac-

tory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline.

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals and intermediate care facilities for the mentally retarded under paragraphs (26) and (31) of section 1902(a), if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

(5) In the case of a State's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to $33\frac{1}{3}$ per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.

(6)(A) Recertifications required under section 1902(a)(44) shall be conducted at least every 60 days in the case of inpatient hospital services.

(B) Such recertifications in the case of services in an intermediate care facility for the mentally retarded shall be conducted at least—

(i) 60 days after the date of the initial certification,

(ii) 180 days after the date of the initial certification,

(iii) 12 months after the date of the initial certification,

(iv) 18 months after the date of the initial certification,

(v) 24 months after the date of the initial certification, and

(vi) every 12 months thereafter.

(C) For purposes of determining compliance with the schedule established by this paragraph, a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required and the State establishes good cause why the physician or other person making such recertification did not meet such schedule.

(i) Payment under the preceding provisions of this section shall not be made—

(1) for organ transplant procedures unless the State plan provides for written standards respecting the coverage of such procedures and unless such standards provide that—

(A) similarly situated individuals are treated alike; and

(B) any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan; or

(2) with respect to any amount expended for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(A) under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2);

(B) at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);

(C) by any individual or entity to whom the State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1862(o) and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments;

(D) beginning on July 1, 2018, under the plan by any provider of services or person whose participation in the State plan is terminated (as described in section 1902(kk)(8)) after the date that is 60 days after the date on which such termination is included in the database or other system under section 1902(ll); or

(E) with respect to any amount expended for such an item or service furnished during calendar quarters beginning on or after October 1, 2017, subject to section 1902(kk)(4)(A)(ii)(II), within a geographic area that is subject to a moratorium imposed under section 1866(j)(7) by a provider or supplier that meets the requirements specified in subparagraph (C)(iii) of such section, during the period of such moratorium; or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan (other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs) to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution

free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for care or services furnished under the plan by a hospital unless such hospital has in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k); or

(5) with respect to any amount expended for any drug product for which payment may not be made under part B of title XVIII because of section 1862(c); or

(6) with respect to any amount expended for inpatient hospital tests (other than in emergency situations) not specifically ordered by the attending physician or other responsible practitioner; or

(7) with respect to any amount expended for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amount exceeds the amount that would be recognized under section 1833(h) for such tests performed for an individual enrolled under part B of title XVIII; or

(8) with respect to any amount expended for medical assistance (A) for nursing facility services to reimburse (or otherwise compensate) a nursing facility for payment of a civil money penalty imposed under section 1919(h) or (B) for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under this title or title XI or for legal expenses in defense of an exclusion or civil money penalty under this title or title XI if there is no reasonable legal ground for the provider's case; or

(10)(A) with respect to covered outpatient drugs unless there is a rebate agreement in effect under section 1927 with respect to such drugs or unless section 1927(a)(3) applies,

(B) with respect to any amount expended for an innovator multiple source drug (as defined in section 1927(k)) dispensed on or after July 1, 1991, if, under applicable State law, a less expensive multiple source drug could have been dispensed, but only to the extent that such amount exceeds the upper payment limit for such multiple source drug;

(C) with respect to covered outpatient drugs described in section 1927(a)(7), unless information respecting utilization data and coding on such drugs that is required to be

submitted under such section is submitted in accordance with such section, and

(D) with respect to any amount expended for reimbursement to a pharmacy under this title for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment under this title (other than with respect to a reasonable restocking fee for such drug); or

(11) with respect to any amount expended for physicians' services furnished on or after the first day of the first quarter beginning more than 60 days after the date of establishment of the physician identifier system under section 1902(x), unless the claim for the services includes the unique physician identifier provided under such system; or

(13) with respect to any amount expended to reimburse (or otherwise compensate) a nursing facility for payment of legal expenses associated with any action initiated by the facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action; or

(14) with respect to any amount expended on administrative costs to carry out the program under section 1928; or

(15) with respect to any amount expended for a single-antigen vaccine and its administration in any case in which the administration of a combined-antigen vaccine was medically appropriate (as determined by the Secretary); or

(16) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; or

(17) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan under this title; or

(18) with respect to any amount expended for home health care services provided by an agency or organization unless the agency or organization provides the State agency on a continuing basis a surety bond in a form specified by the Secretary under paragraph (7) of section 1861(o) and in an amount that is not less than \$50,000 or such comparable surety bond as the Secretary may permit under the last sentence of such section; or

(19) with respect to any amount expended on administrative costs to initiate or pursue litigation described in subsection (d)(3)(B);

(20) with respect to amounts expended for medical assistance provided to an individual described in subclause (XV) or (XVI) of section 1902(a)(10)(A)(ii) for a fiscal year unless the State demonstrates to the satisfaction of the Secretary that the level of State funds expended for such fiscal year for programs to enable working individuals with disabilities to work (other than for such medical assistance) is not less than the level expended for such programs during the most recent State fiscal year ending before the date of the enactment of this paragraph;

(21) with respect to amounts expended for covered outpatient drugs described in section 1927(d)(2)(C) (relating to drugs when used for cosmetic purposes or hair growth), except where medically necessary, and section 1927(d)(2)(K) (relating to

drugs when used for treatment of sexual or erectile dysfunction);

(22) **[with respect to amounts expended]** (A) *with respect to amounts expended* for medical assistance for an individual who declares under section 1137(d)(1)(A) to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title, unless the requirement of section 1902(a)(46)(B) is met; *and*

(B) *in the case of a State that elects to provide a reasonable period to present satisfactory documentary evidence of such citizenship or nationality pursuant to paragraph (2)(C) of section 1902(ee) or paragraph (4) of subsection (x) of this section, for amounts expended for medical assistance for such an individual (other than an individual described in paragraph (2) of such subsection (x)) during such period;*

(23) with respect to amounts expended for medical assistance for covered outpatient drugs (as defined in section 1927(k)(2)) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad;

(24) if a State is required to implement an asset verification program under section 1940 and fails to implement such program in accordance with such section, with respect to amounts expended by such State for medical assistance for individuals subject to asset verification under such section, unless—

(A) the State demonstrates to the Secretary's satisfaction that the State made a good faith effort to comply;

(B) not later than 60 days after the date of a finding that the State is in noncompliance, the State submits to the Secretary (and the Secretary approves) a corrective action plan to remedy such noncompliance; *and*

(C) not later than 12 months after the date of such submission (and approval), the State fulfills the terms of such corrective action plan;

(25) with respect to any amounts expended for medical assistance for individuals for whom the State does not report enrollee encounter data (as defined by the Secretary) to the Medicaid Statistical Information System (MSIS) in a timely manner (as determined by the Secretary);

(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i) other than medical assistance provided through benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2); *or*

(27) with respect to any amounts expended by the State on the basis of a fee schedule for items described in section 1861(n) and furnished on or after January 1, 2018, as determined in the aggregate with respect to each class of such items as defined by the Secretary, in excess of the aggregate amount, if any, that would be paid for such items within such class on a fee-for-service basis under the program under part B of title XVIII, including, as applicable, under a competitive acquisition program under section 1847 in an area of the State.

Nothing in paragraph (1) shall be construed as permitting a State to provide services under its plan under this title that are not reasonable in amount, duration, and scope to achieve their purpose. Paragraphs (1), (2), (16), (17), and (18) shall apply with respect to items or services furnished and amounts expended by or through a managed care entity (as defined in section 1932(a)(1)(B)) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.

(j) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1914.

(k) The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any medicaid managed care organization which meets the requirements of subsection (m) of this section for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this title.

(l)(1) Subject to paragraphs (3) and (4), with respect to any amount expended for personal care services or home health care services requiring an in-home visit by a provider that are provided under a State plan under this title (or under a waiver of the plan) and furnished in a calendar quarter beginning on or after January 1, 2019 (or, in the case of home health care services, on or after January 1, 2023), unless a State requires the use of an electronic visit verification system for such services furnished in such quarter under the plan or such waiver, the Federal medical assistance percentage shall be reduced—

(A) in the case of personal care services—

(i) for calendar quarters in 2019 and 2020, by .25 percentage points;

(ii) for calendar quarters in 2021, by .5 percentage points;

(iii) for calendar quarters in 2022, by .75 percentage points; and

(iv) for calendar quarters in 2023 and each year thereafter, by 1 percentage point; and

(B) in the case of home health care services—

(i) for calendar quarters in 2023 and 2024, by .25 percentage points;

(ii) for calendar quarters in 2025, by .5 percentage points;

(iii) for calendar quarters in 2026, by .75 percentage points; and

(iv) for calendar quarters in 2027 and each year thereafter, by 1 percentage point.

(2) Subject to paragraphs (3) and (4), in implementing the requirement for the use of an electronic visit verification system under paragraph (1), a State shall—

(A) consult with agencies and entities that provide personal care services, home health care services, or both under the State plan (or under a waiver of the plan) to ensure that such system—

(i) is minimally burdensome;

(ii) takes into account existing best practices and electronic visit verification systems in use in the State; and

(iii) is conducted in accordance with the requirements of HIPAA privacy and security law (as defined in section 3009 of the Public Health Service Act);

(B) take into account a stakeholder process that includes input from beneficiaries, family caregivers, individuals who furnish personal care services or home health care services, and other stakeholders, as determined by the State in accordance with guidance from the Secretary; and

(C) ensure that individuals who furnish personal care services, home health care services, or both under the State plan (or under a waiver of the plan) are provided the opportunity for training on the use of such system.

(3) Paragraphs (1) and (2) shall not apply in the case of a State that, as of the date of the enactment of this subsection, requires the use of any system for the electronic verification of visits conducted as part of both personal care services and home health care services, so long as the State continues to require the use of such system with respect to the electronic verification of such visits.

(4)(A) In the case of a State described in subparagraph (B), the reduction under paragraph (1) shall not apply—

(i) in the case of personal care services, for calendar quarters in 2019; and

(ii) in the case of home health care services, for calendar quarters in 2023.

(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that demonstrates to the Secretary that the State—

(i) has made a good faith effort to comply with the requirements of paragraphs (1) and (2) (including by taking steps to adopt the technology used for an electronic visit verification system); and

(ii) in implementing such a system, has encountered unavoidable system delays.

(5) In this subsection:

(A) The term “electronic visit verification system” means, with respect to personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to—

(i) the type of service performed;

(ii) the individual receiving the service;

(iii) the date of the service;

(iv) the location of service delivery;

(v) the individual providing the service; and

(vi) the time the service begins and ends.

(B) The term “home health care services” means services described in section 1905(a)(7) provided under a State plan under this title (or under a waiver of the plan).

(C) The term “personal care services” means personal care services provided under a State plan under this title (or under a waiver of the plan), including services provided under section 1905(a)(24), 1915(c), 1915(i), 1915(j), or 1915(k) or under a wavier under section 1115.

(6)(A) In the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system operated by the State or a contractor on behalf of the State, the Secretary shall pay to the State, for each quarter, an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such system, and 75 per centum of so much of the sums for the operation and maintenance of such system.

(B) Subparagraph (A) shall not apply in the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system that is not operated by the State or a contractor on behalf of the State.

(m)(1)(A) The term “medicaid managed care organization” means a health maintenance organization, an eligible organization with a contract under section 1876 or a Medicare+Choice organization with a contract under part C of title XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1902(w) and—

(i) makes services it provides to individuals eligible for benefits under this title accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and

(ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State, meets the requirements of subparagraph (C)(i) (if applicable), and which assures that individuals eligible for benefits under this title are in no case held liable for debts of the organization in case of the organization’s insolvency.

An organization that is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) is deemed to meet the requirements of clauses (i) and (ii).

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a medicaid managed care organization within the meaning of subparagraph (A), shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

(C)(i) Subject to clause (ii), a provision meets the requirements of this subparagraph for an organization if the organization meets solvency standards established by the State for private health maintenance organizations or is licensed or certified by the State as a risk-bearing entity.

(ii) Clause (i) shall not apply to an organization if—

(I) the organization is not responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and physicians’ services;

(II) the organization is a public entity;

(III) the solvency of the organization is guaranteed by the State; or

(IV) the organization is (or is controlled by) one or more Federally-qualified health centers and meets solvency standards established by the State for such an organization.

For purposes of subclause (IV), the term “control” means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.

(2)(A) Except as provided in subparagraphs (B), (C), and (G), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a) or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary has determined that the entity is a Medicaid managed care organization organization as defined in paragraph (1);

(iii) such services are provided for the benefit of individuals eligible for benefits under this title in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of \$1,000,000 for 1998 and, for a subsequent year, the amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year;

(iv) such contract provides that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain (I) to the ability of the entity to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

(v) such contract provides that in the entity’s enrollment, reenrollment, or disenrollment of individuals who are eligible for benefits under this title and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

(vi) such contract (I) permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment in accordance with section 1932(a)(4), and (II) provides for notification in accordance with such section of each such individual, at the time of the individual’s enrollment, of such right to terminate such enrollment;

(vii) such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State’s plan and (II) other than through the organization because the services were immediately required due to an unforeseen illness, injury,

or condition, either the entity or the State provides for reimbursement with respect to those services,

(viii) such contract provides for disclosure of information in accordance with section 1124 and paragraph (4) of this subsection;

(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services with a Federally-qualified health center or a rural health clinic, that the entity shall provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a Federally-qualified health center or a rural health clinic;

(x) any physician incentive plan that it operates meets the requirements described in section 1876(i)(8);

(xi) such contract provides for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary;

(xii) such contract, and the entity complies with the applicable requirements of section 1932; and

(xiii) such contract provides that (I) covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the State shall collect such rebates from manufacturers, (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates, and (III) the entity shall report to the State, on such timely and periodic basis as specified by the Secretary in order to include in the information submitted by the State to a manufacturer and the Secretary under section 1927(b)(2)(A), information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1927 are not subject to the requirements of that section) and such other data as the Secretary determines necessary to carry out this subsection.

(B) Subparagraph (A) except with respect to clause (ix) of subparagraph (A), does not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

(i)(I) received a grant of at least \$100,000 in the fiscal year ending June 30, 1976, under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act, and for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title has been the recipient of a grant under either such section; and

(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) and, to the extent required by section 1902(a)(10)(D) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a); or

(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

(I) which received in the fiscal year ending June 30, 1976, at least \$100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation risk basis or on any other risk basis; or

(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this title on a prepaid risk basis prior to 1970.

(G) In the case of an entity which is receiving (and has received during the previous two years) a grant of at least \$100,000 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act or is receiving (and has received during the previous two years) at least \$100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, clause (i) of subparagraph (A) shall not apply.

(H) In the case of an individual who—

(i) in a month is eligible for benefits under this title and enrolled with a medicaid managed care organization with a contract under this paragraph or with a primary care case manager with a contract described in section 1905(t)(3),

(ii) in the next month (or in the next 2 months) is not eligible for such benefits, but

(iii) in the succeeding month is again eligible for such benefits,

the State plan, subject to subparagraph (A)(vi), may enroll the individual for that succeeding month with the organization described in clause (i) if the organization continues to have a contract under this paragraph with the State or with the manager described in such clause if the manager continues to have a contract described in section 1905(t)(3) with the State.

(3) No payment shall be made under this title to a State with respect to expenditures incurred by the State for payment for services provided by a managed care entity (as defined under section 1932(a)(1)) under the State plan under this title (or under a waiver of the plan) unless the State—

(A) beginning on July 1, 2018, has a contract with such entity that complies with the requirement specified in section 1932(d)(5); and

(B) beginning on January 1, 2018, complies with the requirement specified in section 1932(d)(6)(A).

(4)(A) Each medicaid managed care organization which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General a description of transactions between the organization and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

(i) Any sale or exchange, or leasing of any property between the organization and such a party.

(ii) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

(iii) Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported respecting an organization which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) Each organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

(5)(A) If the Secretary determines that an entity with a contract under this subsection—

(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(ii) imposes premiums on individuals enrolled under this subsection in excess of the premiums permitted under this title;

(iii) acts to discriminate among individuals in violation of the provision of paragraph (2)(A)(v), including expulsion or refusal to re-enroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this subsection) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(iv) misrepresents or falsifies information that is furnished—

(I) to the Secretary or the State under this subsection,

or

(II) to an individual or to any other entity under this subsection, or

(v) fails to comply with the requirements of section 1876(i)(8),

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in subparagraph (B).

(B) The remedies described in this subparagraph are—

(i) civil money penalties of not more than \$25,000 for each determination under subparagraph (A), or, with respect to a determination under clause (iii) or (iv)(I) of such subparagraph, of not more than \$100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iii), \$15,000 for each individual not enrolled as a result of a practice described in such subparagraph, or

(ii) denial of payment to the State for medical assistance furnished under the contract under this subsection for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(6)(A) For purposes of this subsection and section 1902(e)(2)(A), in the case of the State of New Jersey, the term “contract” shall be deemed to include an undertaking by the State agency, in the State plan under this title, to operate a program meeting all requirements of this subsection.

(B) The undertaking described in subparagraph (A) must provide—

(i) for the establishment of a separate entity responsible for the operation of a program meeting the requirements of this subsection, which entity may be a subdivision of the State agency administering the State plan under this title;

(ii) for separate accounting for the funds used to operate such program; and

(iii) for setting the capitation rates and any other payment rates for services provided in accordance with this subsection using a methodology satisfactory to the Secretary designed to ensure that total Federal matching payments under this title for such services will be lower than the matching payments that would be made for the same services, if provided under the State plan on a fee for service basis to an actuarially equivalent population.

(C) The undertaking described in subparagraph (A) shall be subject to approval (and annual re-approval) by the Secretary in the same manner as a contract under this subsection.

(D) The undertaking described in subparagraph (A) shall not be eligible for a waiver under section 1915(b).

(o) Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for

an individual under its State plan approved under this title to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

(p)(1) When a political subdivision of a State makes, for the State of which it is a political subdivision, or one State makes, for another State, the enforcement and collection of rights of support or payment assigned under section 1912, pursuant to a cooperative arrangement under such section (either within or outside of such State), there shall be paid to such political subdivision or such other State from amounts which would otherwise represent the Federal share of payments for medical assistance provided to the eligible individuals on whose behalf such enforcement and collection was made, an amount equal to 15 percent of any amount collected which is attributable to such rights of support or payment.

(2) Where more than one jurisdiction is involved in such enforcement or collection, the amount of the incentive payment determined under paragraph (1) shall be allocated among the jurisdictions in a manner to be prescribed by the Secretary.

(q) For the purposes of this section, the term "State medicaid fraud control unit" means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

(1) The entity (A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations, (B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, that (i) assure its referral of suspected criminal violations relating to the program under this title to the appropriate authority or authorities in the State for prosecution and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions, or (C) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this title.

(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan under this title.

(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with (A) any aspect of the provision of medical assist-

ance and the activities of providers of such assistance under the State plan under this title; and (B) upon the approval of the Inspector General of the relevant Federal agency, any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (as defined in section 1128B(f)(1)), if the suspected fraud or violation of law in such case or investigation is primarily related to the State plan under this title.

(4)(A) The entity has—

(i) procedures for reviewing complaints of abuse or neglect of patients in health care facilities which receive payments under the State plan under this title;

(ii) at the option of the entity, procedures for reviewing complaints of abuse or neglect of patients residing in board and care facilities; and

(iii) procedures for acting upon such complaints under the criminal laws of the State or for referring such complaints to other State agencies for action.

(B) For purposes of this paragraph, the term “board and care facility” means a residential setting which receives payment (regardless of whether such payment is made under the State plan under this title) from or on behalf of two or more unrelated adults who reside in such facility, and for whom one or both of the following is provided:

(i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant.

(ii) A substantial amount of personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer, positioning, self-medication, body care, travel to medical services, essential shopping, meal preparation, laundry, and housework.

(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments that are made under the State plan or under any Federal health care program (as so defined) to health care facilities and that are discovered by the entity in carrying out its activities. All funds collected in accordance with this paragraph shall be credited exclusively to, and available for expenditure under, the Federal health care program (including the State plan under this title) that was subject to the activity that was the basis for the collection.

(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity’s activities.

(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.

(r)(1) In order to receive payments under subsection (a) for use of automated data systems in administration of the State plan under this title, a State must, in addition to meeting the require-

ments of paragraph (3), have in operation mechanized claims processing and information retrieval systems that meet the requirements of this subsection and that the Secretary has found—

(A) are adequate to provide efficient, economical, and effective administration of such State plan;

(B) are compatible with the claims processing and information retrieval systems used in the administration of title XVIII, and for this purpose—

(i) have a uniform identification coding system for providers, other payees, and beneficiaries under this title or title XVIII;

(ii) provide liaison between States and carriers and intermediaries with agreements under title XVIII to facilitate timely exchange of appropriate data;

(iii) provide for exchange of data between the States and the Secretary with respect to persons sanctioned under this title or title XVIII; and

(iv) effective for claims filed on or after October 1, 2010, incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);

(C) are capable of providing accurate and timely data;

(D) are complying with the applicable provisions of part C of title XI;

(E) are designed to receive provider claims in standard formats to the extent specified by the Secretary; and

(F) effective for claims filed on or after January 1, 1999, provide for electronic transmission of claims data in the format specified by the Secretary and consistent with the Medicaid Statistical Information System (MSIS) (including detailed individual enrollee encounter data and other information that the Secretary may find necessary and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine).

(2) In order to meet the requirements of this paragraph, mechanized claims processing and information retrieval systems must meet the following requirements:

(A) The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

(B) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's medicaid fraud control unit (if any) certified under subsection (q) of this section.

(C) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary.

(3) In order to meet the requirements of this paragraph, a State must have in operation an eligibility determination system which provides for data matching through the Public Assistance Reporting Information System (PARIS) facilitated by the Secretary (or any successor system), including matching with medical assistance programs operated by other States.

(4) For purposes of paragraph (1)(B)(iv), the Secretary shall do the following:

(A) Not later than September 1, 2010:

(i) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under this title.

(ii) Identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under this title with respect to items or services for which States provide medical assistance under this title and no national correct coding methodologies have been established under such Initiative with respect to title XVIII.

(iii) Notify States of—

(I) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

(II) how States are to incorporate such methodologies into claims filed under this title.

(B) Not later than March 1, 2011, submit a report to Congress that includes the notice to States under clause (iii) of subparagraph (A) and an analysis supporting the identification of the methodologies made under clauses (i) and (ii) of subparagraph (A).

(s) Notwithstanding the preceding provisions of this section, no payment shall be made to a State under this section for expenditures for medical assistance under the State plan consisting of a designated health service (as defined in subsection (h)(6) of section 1877) furnished to an individual on the basis of a referral that would result in the denial of payment for the service under title XVIII if such title provided for coverage of such service to the same extent and under the same terms and conditions as under the State plan, and subsections (f) and (g)(5) of such section shall apply to a provider of such a designated health service for which payment may be made under this title in the same manner as such subsections apply to a provider of such a service for which payment may be made under such title.

(t)(1) For purposes of subsection (a)(3)(F), the payments described in this paragraph to encourage the adoption and use of certified EHR technology are payments made by the State in accordance with this subsection —

(A) to Medicaid providers described in paragraph (2)(A) not in excess of 85 percent of net average allowable costs (as defined in paragraph (3)(E)) for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology) with respect to such providers; and

(B) to Medicaid providers described in paragraph (2)(B) not in excess of the maximum amount permitted under paragraph (5) for the provider involved.

(2) In this subsection and subsection (a)(3)(F), the term “Medicaid provider” means—

(A) an eligible professional (as defined in paragraph (3)(B))—

(i) who is not hospital-based and has at least 30 percent of the professional’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title;

(ii) who is not described in clause (i), who is a pediatrician, who is not hospital-based, and who has at least 20 percent of the professional’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title; and

(iii) who practices predominantly in a Federally qualified health center or rural health clinic and has at least 30 percent of the professional’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to needy individuals (as defined in paragraph (3)(F)); and

(B)(i) a children’s hospital, or

(ii) an acute-care hospital that is not described in clause (i) and that has at least 10 percent of the hospital’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title.

An eligible professional shall not qualify as a Medicaid provider under this subsection unless any right to payment under sections 1848(o) and 1853(l) with respect to the eligible professional has been waived in a manner specified by the Secretary. For purposes of calculating patient volume under subparagraph (A)(iii), insofar as it is related to uncompensated care, the Secretary may require the adjustment of such uncompensated care data so that it would be an appropriate proxy for charity care, including a downward adjustment to eliminate bad debt data from uncompensated care. In applying subparagraphs (A) and (B)(ii), the methodology established by the Secretary for patient volume shall include individuals enrolled in a Medicaid managed care plan (under section 1903(m) or section 1932).

(3) In this subsection and subsection (a)(3)(F):

(A) The term “certified EHR technology” means a qualified electronic health record (as defined in 3000(13) of the Public Health Service Act) that is certified pursuant to section 3001(c)(5) of such Act as meeting standards adopted under section 3004 of such Act that are applicable to the type of record

involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

(B) The term “eligible professional” means a—

- (i) physician;
- (ii) dentist;
- (iii) certified nurse mid-wife;
- (iv) nurse practitioner; and
- (v) physician assistant insofar as the assistant is practicing in a rural health clinic that is led by a physician assistant or is practicing in a Federally qualified health center that is so led.

(C) The term “average allowable costs” means, with respect to certified EHR technology of Medicaid providers described in paragraph (2)(A) for—

- (i) the first year of payment with respect to such a provider, the average costs for the purchase and initial implementation or upgrade of such technology (and support services including training that is for, or is necessary for the adoption and initial operation of, such technology) for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C); and
- (ii) a subsequent year of payment with respect to such a provider, the average costs not described in clause (i) relating to the operation, maintenance, and use of such technology for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C).

(D) The term “hospital-based” means, with respect to an eligible professional, a professional (such as a pathologist, anesthesiologist, or emergency physician) who furnishes substantially all of the individual’s professional services in a hospital inpatient or emergency room setting and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

(E) The term “net average allowable costs” means, with respect to a Medicaid provider described in paragraph (2)(A), average allowable costs reduced by the average payment the Secretary estimates will be made to such Medicaid providers (determined on a percentage or other basis for such classes or types of providers as the Secretary may specify) from other sources (other than under this subsection, or by the Federal government or a State or local government) that is directly attributable to payment for certified EHR technology or support services described in subparagraph (C).

(F) The term “needy individual” means, with respect to a Medicaid provider, an individual—

- (i) who is receiving assistance under this title;
- (ii) who is receiving assistance under title XXI;

(iii) who is furnished uncompensated care by the provider; or

(iv) for whom charges are reduced by the provider on a sliding scale basis based on an individual's ability to pay.

(4)(A) With respect to a Medicaid provider described in paragraph (2)(A), subject to subparagraph (B), in no case shall—

(i) the net average allowable costs under this subsection for the first year of payment (which may not be later than 2016), which is intended to cover the costs described in paragraph (3)(C)(i), exceed \$25,000 (or such lesser amount as the Secretary determines based on studies conducted under subparagraph (C));

(ii) the net average allowable costs under this subsection for a subsequent year of payment, which is intended to cover costs described in paragraph (3)(C)(ii), exceed \$10,000; and

(iii) payments be made for costs described in clause (ii) after 2021 or over a period of longer than 5 years.

(B) In the case of Medicaid provider described in paragraph (2)(A)(ii), the dollar amounts specified in subparagraph (A) shall be $\frac{2}{3}$ of the dollar amounts otherwise specified.

(C) For the purposes of determining average allowable costs under this subsection, the Secretary shall study the average costs to Medicaid providers described in paragraph (2)(A) of purchase and initial implementation and upgrade of certified EHR technology described in paragraph (3)(C)(i) and the average costs to such providers of operations, maintenance, and use of such technology described in paragraph (3)(C)(ii). In determining such costs for such providers, the Secretary may utilize studies of such amounts submitted by States.

(5)(A) In no case shall the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) exceed—

(i) in the aggregate the product of—

(I) the overall hospital EHR amount for the provider computed under subparagraph (B); and

(II) the Medicaid share for such provider computed under subparagraph (C);

(ii) in any year 50 percent of the product described in clause (i); and

(iii) in any 2-year period 90 percent of such product.

(B) For purposes of this paragraph, the overall hospital EHR amount, with respect to a Medicaid provider, is the sum of the applicable amounts specified in section 1886(n)(2)(A) for such provider for the first 4 payment years (as estimated by the Secretary) determined as if the Medicare share specified in clause (ii) of such section were 1. The Secretary shall establish, in consultation with the State, the overall hospital EHR amount for each such Medicaid provider eligible for payments under paragraph (1)(B). For purposes of this subparagraph in computing the amounts under section 1886(n)(2)(C) for payment years after the first payment year, the Secretary shall assume that in subsequent payment years discharges increase at the average annual rate of growth of the most recent 3 years for which discharge data are available per year.

(C) The Medicaid share computed under this subparagraph, for a Medicaid provider for a period specified by the Secretary, shall be calculated in the same manner as the Medicare share under section 1886(n)(2)(D) for such a hospital and period, except that there shall be substituted for the numerator under clause (i) of such section the amount that is equal to the number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals who are receiving medical assistance under this title and who are not described in section 1886(n)(2)(D)(i). In computing inpatient-bed-days under the previous sentence, the Secretary shall take into account inpatient-bed-days attributable to inpatient-bed-days that are paid for individuals enrolled in a Medicaid managed care plan (under section 1903(m) or section 1932).

(D) In no case may the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) be paid—

(i) for any year beginning after 2016 unless the provider has been provided payment under paragraph (1)(B) for the previous year; and

(ii) over a period of more than 6 years of payment.

(6) Payments described in paragraph (1) are not in accordance with this subsection unless the following requirements are met:

(A)(i) The State provides assurances satisfactory to the Secretary that amounts received under subsection (a)(3)(F) with respect to payments to a Medicaid provider are paid, subject to clause (ii), directly to such provider (or to an employer or facility to which such provider has assigned payments) without any deduction or rebate.

(ii) Amounts described in clause (i) may also be paid to an entity promoting the adoption of certified EHR technology, as designated by the State, if participation in such a payment arrangement is voluntary for the eligible professional involved and if such entity does not retain more than 5 percent of such payments for costs not related to certified EHR technology (and support services including maintenance and training) that is for, or is necessary for the operation of, such technology.

(B) A Medicaid provider described in paragraph (2)(A) is responsible for payment of the remaining 15 percent of the net average allowable cost and shall be determined to have met such responsibility to the extent that the payment to the Medicaid provider is not in excess of 85 percent of the net average allowable cost.

(C)(i) Subject to clause (ii), with respect to payments to a Medicaid provider—

(I) for the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates that it is engaged in efforts to adopt, implement, or upgrade certified EHR technology; and

(II) for a year of payment, other than the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates meaningful use of certified EHR technology through a means that is approved by the State and acceptable to the Secretary, and that may

be based upon the methodologies applied under section 1848(o) or 1886(n).

(ii) In the case of a Medicaid provider who has completed adopting, implementing, or upgrading such technology prior to the first year of payment to the Medicaid provider under this subsection, clause (i)(I) shall not apply and clause (i)(II) shall apply to each year of payment to the Medicaid provider under this subsection, including the first year of payment.

(D) To the extent specified by the Secretary, the certified EHR technology is compatible with State or Federal administrative management systems.

For purposes of subparagraph (B), a Medicaid provider described in paragraph (2)(A) may accept payments for the costs described in such subparagraph from a State or local government. For purposes of subparagraph (C), in establishing the means described in such subparagraph, which may include clinical quality reporting to the State, the State shall ensure that populations with unique needs, such as children, are appropriately addressed.

(7) With respect to Medicaid providers described in paragraph (2)(A), the Secretary shall ensure coordination of payment with respect to such providers under sections 1848(o) and 1853(l) and under this subsection to assure no duplication of funding. Such coordination shall include, to the extent practicable, a data matching process between State Medicaid agencies and the Centers for Medicare & Medicaid Services using national provider identifiers. For such purposes, the Secretary may require the submission of such data relating to payments to such Medicaid providers as the Secretary may specify.

(8) In carrying out paragraph (6)(C), the State and Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this title and title XVIII. In doing so, the Secretary may deem satisfaction of requirements for such meaningful use for a payment year under title XVIII to be sufficient to qualify as meaningful use under this subsection. The Secretary may also specify the reporting periods under this subsection in order to carry out this paragraph.

(9) In order to be provided Federal financial participation under subsection (a)(3)(F)(ii), a State must demonstrate to the satisfaction of the Secretary, that the State—

(A) is using the funds provided for the purposes of administering payments under this subsection, including tracking of meaningful use by Medicaid providers;

(B) is conducting adequate oversight of the program under this subsection, including routine tracking of meaningful use attestations and reporting mechanisms; and

(C) is pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information under this title, subject to applicable laws and regulations governing such exchange.

(10) The Secretary shall periodically submit reports to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on status, progress, and oversight of payments described in paragraph (1), including

steps taken to carry out paragraph (7). Such reports shall also describe the extent of adoption of certified EHR technology among Medicaid providers resulting from the provisions of this subsection and any improvements in health outcomes, clinical quality, or efficiency resulting from such adoption.

(u)(1)(A) Notwithstanding subsection (a)(1), if the ratio of a State's erroneous excess payments for medical assistance (as defined in subparagraph (D)) to its total expenditures for medical assistance under the State plan approved under this title exceeds 0.03, for the period consisting of the third and fourth quarters of fiscal year 1983, or for any full fiscal year thereafter, then the Secretary shall make no payment for such period or fiscal year with respect to so much of such erroneous excess payments as exceeds such allowable error rate of 0.03.

(B) The Secretary may waive, in certain limited cases, all or part of the reduction required under subparagraph (A) with respect to any State if such State is unable to reach the allowable error rate for a period or fiscal year despite a good faith effort by such State.

(C) In estimating the amount to be paid to a State under subsection (d), the Secretary shall take into consideration the limitation on Federal financial participation imposed by subparagraph (A) and shall reduce the estimate he makes under subsection (d)(1), for purposes of payment to the State under subsection (d)(3), in light of any expected erroneous excess payments for medical assistance (estimated in accordance with such criteria, including sampling procedures, as he may prescribe and subject to subsequent adjustment, if necessary, under subsection (d)(2)).

(D)(i) For purposes of this subsection, the term "erroneous excess payments for medical assistance" means the total of—

(I) payments under the State plan with respect to ineligible individuals and families, and

(II) overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.

(ii) In determining the amount of erroneous excess payments for medical assistance to an ineligible individual or family under clause (i)(I), if such ineligibility is the result of an error in determining the amount of the resources of such individual or family, the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment with respect to such individual or family, or (II) the difference between the actual amount of such resources and the allowable resource level established under the State plan.

(iii) In determining the amount of erroneous excess payments for medical assistance to an individual or family under clause (i)(II), the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment on behalf of the individual or family, or (II) the difference between the actual amount incurred for medical care by the individual or family and the amount which should have been incurred in order to establish eligibility for medical assistance.

(iv) In determining the amount of erroneous excess payments, there shall not be included any error resulting from a failure of an

individual to cooperate or give correct information with respect to third-party liability as required under section 1912(a)(1)(C) or 402(a)(26)(C) or with respect to payments made in violation of section 1906.

(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1920(b)(1)), for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section, for medical assistance provided to an individual described in subsection (a) of section 1920B during a presumptive eligibility period under such section, or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1902(a)(47)(B) to be a qualified entity for such purpose.

(E) For purposes of subparagraph (D), there shall be excluded, in determining both erroneous excess payments for medical assistance and total expenditures for medical assistance—

(i) payments with respect to any individual whose eligibility therefor was determined exclusively by the Secretary under an agreement pursuant to section 1634 and such other classes of individuals as the Secretary may by regulation prescribe whose eligibility was determined in part under such an agreement; and

(ii) payments made as the result of a technical error.

(2) The State agency administering the plan approved under this title shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous excess payments made (or expected, with respect to future periods specified by the Secretary) in connection with its administration of such plan, together with any other data he requests that are reasonably necessary for him to carry out the provisions of this subsection.

(3)(A) If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through contractual or such other arrangements as he may find appropriate, shall establish the error rates for that State on the basis of the best data reasonably available to him and in accordance with such techniques for sampling and estimating as he finds appropriate.

(B) In any case in which it is necessary for the Secretary to exercise his authority under subparagraph (A) to determine a State's error rates for a fiscal year, the amount that would otherwise be payable to such State under this title for quarters in such year shall be reduced by the costs incurred by the Secretary in making (directly or otherwise) such determination.

(4) This subsection shall not apply with respect to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, or American Samoa.

(v)(1) Notwithstanding the preceding provisions of this section, except as provided in paragraphs (2) and (4), no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence

or otherwise permanently residing in the United States under color of law.

(2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if—

(A) such care and services are necessary for the treatment of an emergency medical condition of the alien,

(B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title XVI, or a State supplementary payment), and

(C) such care and services are not related to an organ transplant procedure.

(3) For purposes of this subsection, the term “emergency medical condition” means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(A) placing the patient’s health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(4)(A) A State may elect (in a plan amendment under this title) to provide medical assistance under this title, notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, to children and pregnant women who are lawfully residing in the United States (including battered individuals described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

(ii) CHILDREN.—Individuals under 21 years of age, including optional targeted low-income children described in section 1905(u)(2)(B).

(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

(C) As part of the State’s ongoing eligibility redetermination requirements and procedures for an individual provided medical assistance as a result of an election by the State under subparagraph (A), a State shall verify that the individual continues to lawfully reside in the United States using the documentation presented to the State by the individual on initial enrollment. If the State cannot successfully verify that the individual is lawfully residing in the United States in this manner, it shall require that the individual provide the State with further documentation or other evidence to verify that the individual is lawfully residing in the United States.

(w)(1)(A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—

(i) from provider-related donations (as defined in paragraph (2)(A)), other than—

(I) bona fide provider-related donations (as defined in paragraph (2)(B)), and

(II) donations described in paragraph (2)(C);

(ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B));

(iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax; or

(iv) only with respect to State fiscal years (or portions thereof) occurring on or after January 1, 1992, and before October 1, 1995, from broad-based health care related taxes to the extent the amount of such taxes collected exceeds the limit established under paragraph (5).

(B) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State under subsection (a)(7) for all quarters in a Federal fiscal year (beginning with fiscal year 1993), the total amount expended during the fiscal year for administrative expenditures under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during such quarters from donations described in paragraph (2)(C), to the extent the amount of such donations exceeds 10 percent of the amounts expended under the State plan under this title during the fiscal year for purposes described in paragraphs (2), (3), (4), (6), and (7) of subsection (a).

(C)(i) Except as otherwise provided in clause (ii), subparagraph (A)(i) shall apply to donations received on or after January 1, 1992.

(ii) Subject to the limits described in clause (iii) and subparagraph (E), subparagraph (A)(i) shall not apply to donations received before the effective date specified in subparagraph (F) if such donations are received under programs in effect or as described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

(iii) In applying clause (ii) in the case of donations received in State fiscal year 1993, the maximum amount of such donations to which such clause may be applied may not exceed the total amount of such donations received in the corresponding period in State fiscal year 1992 (or not later than 5 days after the last day of the corresponding period).

(D)(i) Except as otherwise provided in clause (ii), subparagraphs (A)(ii) and (A)(iii) shall apply to taxes received on or after January 1, 1992.

(ii) Subparagraphs (A)(ii) and (A)(iii) shall not apply to impermissible taxes (as defined in clause (iii)) received before the effective date specified in subparagraph (F) to the extent the taxes (including the tax rate or base) were in effect, or the legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(iii) In this subparagraph and subparagraph (E), the term “impermissible tax” means a health care related tax for which a reduction may be made under clause (ii) or (iii) of subparagraph (A).

(E)(i) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for the portion of State fiscal year 1992 occurring during calendar year 1992 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in the portion of that fiscal year.

(ii) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for State fiscal year 1993 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in that fiscal year.

(F) In this paragraph in the case of a State—

(i) except as provided in clause (iii), with a State fiscal year beginning on or before July 1, the effective date is October 1, 1992,

(ii) except as provided in clause (iii), with a State fiscal year that begins after July 1, the effective date is January 1, 1993, or

(iii) with a State legislature which is not scheduled to have a regular legislative session in 1992, with a State legislature which is not scheduled to have a regular legislative session in 1993, or with a provider-specific tax enacted on November 4, 1991, the effective date is July 1, 1993.

(2)(A) In this subsection (except as provided in paragraph (6)), the term “provider-related donation” means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—

(i) a health care provider (as defined in paragraph (7)(B)),

(ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or

(iii) an entity providing goods or services under the State plan for which payment is made to the State under paragraph (2), (3), (4), (6), or (7) of subsection (a).

(B) For purposes of paragraph (1)(A)(i)(I), the term “bona fide provider-related donation” means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this title to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the pre-

vious sentence that will be considered to be bona fide provider-related donations.

(C) For purposes of paragraph (1)(A)(i)(II), donations described in this subparagraph are funds expended by a hospital, clinic, or similar entity for the direct cost (including costs of training and of preparing and distributing outreach materials) of State or local agency personnel who are stationed at the hospital, clinic, or entity to determine the eligibility of individuals for medical assistance under this title and to provide outreach services to eligible or potentially eligible individuals.

(3)(A) In this subsection (except as provided in paragraph (6)), the term “health care related tax” means a tax (as defined in paragraph (7)(F)) that—

(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or

(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

(B) In this subsection, the term “broad-based health care related tax” means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A)) or with respect to providers of such items or services and which, except as provided in subparagraphs (D), (E), and (F)—

(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

(ii) is imposed uniformly (in accordance with subparagraph (C)).

(C)(i) Subject to clause (ii), for purposes of subparagraph (B)(ii), a tax is considered to be imposed uniformly if—

(I) in the case of a tax consisting of a licensing fee or similar tax on a class of health care items or services (or providers of such items or services), the amount of the tax imposed is the same for every provider providing items or services within the class;

(II) in the case of a tax consisting of a licensing fee or similar tax imposed on a class of health care items or services (or providers of such services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of such items or services in the class;

(III) in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues,

relating to the provision of all such items or services (or all such providers) in the State (or, in the case of a tax imposed by a unit of local government within the State, in the area over which the unit has jurisdiction); or

(IV) in the case of any other tax, the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.

(ii) Subject to subparagraphs (D) and (E), a tax imposed with respect to a class of health care items and services is not considered to be imposed uniformly if the tax provides for any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid in a manner that is inconsistent with subclauses (I) and (II) of subparagraph (E)(ii) or provides for a hold harmless provision described in paragraph (4).

(D) A tax imposed with respect to a class of health care items and services is considered to be imposed uniformly—

(i) notwithstanding that the tax is not imposed with respect to items or services (or the providers thereof) for which payment is made under a State plan under this title or title XVIII, or

(ii) in the case of a tax described in subparagraph (C)(i)(III), notwithstanding that the tax provides for exclusion (in whole or in part) of revenues or receipts from a State plan under this title or title XVIII.

(E)(i) A State may submit an application to the Secretary requesting that the Secretary treat a tax as a broad-based health care related tax, notwithstanding that the tax does not apply to all health care items or services in class (or all providers of such items and services), provides for a credit, deduction, or exclusion, is not applied uniformly, or otherwise does not meet the requirements of subparagraph (B) or (C). Permissible waivers may include exemptions for rural or sole-community providers.

(ii) The Secretary shall approve such an application if the State establishes to the satisfaction of the Secretary that—

(I) the net impact of the tax and associated expenditures under this title as proposed by the State is generally redistributive in nature, and

(II) the amount of the tax is not directly correlated to payments under this title for items or services with respect to which the tax is imposed.

The Secretary shall by regulation specify types of credits, exclusions, and deductions that will be considered to meet the requirements of this subparagraph.

(F) In no case shall a tax not qualify as a broad-based health care related tax under this paragraph because it does not apply to a hospital that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code and that does not accept payment under the State plan under this title or under title XVIII.

(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

(A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this title) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.

(B) All or any portion of the payment made under this title to the taxpayer varies based only upon the amount of the total tax paid.

(C)(i) The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.

(ii) For purposes of clause (i), a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on November 1, 2006, except that for portions of fiscal years beginning on or after January 1, 2008, and before October 1, 2011, "5.5 percent" shall be substituted for "6 percent" each place it appears.

The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

(5)(A) For purposes of this subsection, the limit under this subparagraph with respect to a State is an amount equal to 25 percent (or, if greater, the State base percentage, as defined in subparagraph (B)) of the non-Federal share of the total amount expended under the State plan during a State fiscal year (or portion thereof), as it would be determined pursuant to paragraph (1)(A) without regard to paragraph (1)(A)(iv).

(B)(i) In subparagraph (A), the term "State base percentage" means, with respect to a State, an amount (expressed as a percentage) equal to—

(I) the total of the amount of health care related taxes (whether or not broad-based) and the amount of provider-related donations (whether or not bona fide) projected to be collected (in accordance with clause (ii)) during State fiscal year 1992, divided by

(II) the non-Federal share of the total amount estimated to be expended under the State plan during such State fiscal year.

(ii) For purposes of clause (i)(I), in the case of a tax that is not in effect throughout State fiscal year 1992 or the rate (or base) of which is increased during such fiscal year, the Secretary shall project the amount to be collected during such fiscal year as if the tax (or increase) were in effect during the entire State fiscal year.

(C)(i) The total amount of health care related taxes under subparagraph (B)(i)(I) shall be determined by the Secretary based on only those taxes (including the tax rate or base) which were in effect, or for which legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(ii) The amount of provider-related donations under subparagraph (B)(i)(I) shall be determined by the Secretary based on pro-

grams in effect on September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

(iii) The amount of expenditures described in subparagraph (B)(i)(II) shall be determined by the Secretary based on the best data available as of the date of the enactment of this subsection.

(6)(A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

(B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related tax.

(7) For purposes of this subsection:

(A) Each of the following shall be considered a separate class of health care items and services:

- (i) Inpatient hospital services.
- (ii) Outpatient hospital services.
- (iii) Nursing facility services (other than services of intermediate care facilities for the mentally retarded).
- (iv) Services of intermediate care facilities for the mentally retarded.
- (v) Physicians' services.
- (vi) Home health care services.
- (vii) Outpatient prescription drugs.
- (viii) Services of managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).

(ix) Such other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.

(B) The term "health care provider" means an individual or person that receives payments for the provision of health care items or services.

(C) An entity is considered to be "related" to a health care provider if the entity—

- (i) is an organization, association, corporation or partnership formed by or on behalf of health care providers;
- (ii) is a person with an ownership or control interest (as defined in section 1124(a)(3)) in the provider;
- (iii) is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or
- (iv) has a similar, close relationship (as defined in regulations) to the provider.

(D) The term “State” means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

(E) The “State fiscal year” means, with respect to a specified year, a State fiscal year ending in that specified year.

(F) The term “tax” includes any licensing fee, assessment, or other mandatory payment, but does not include payment of a criminal or civil fine or penalty (other than a fine or penalty imposed in lieu of or instead of a fee, assessment, or other mandatory payment).

(G) The term “unit of local government” means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State.

(x)(1) For purposes of section 1902(a)(46)(B)(i), the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

(2) The requirement of paragraph (1) shall not apply to an individual declaring to be a citizen or national of the United States who is eligible for medical assistance under this title—

(A) and is entitled to or enrolled for benefits under any part of title XVIII;

(B) and is receiving—

(i) disability insurance benefits under section 223 or monthly insurance benefits under section 202 based on such individual’s disability (as defined in section 223(d)); or

(ii) supplemental security income benefits under title XVI;

(C) and with respect to whom—

(i) child welfare services are made available under part B of title IV on the basis of being a child in foster care; or

(ii) adoption or foster care assistance is made available under part E of title IV;

(D) pursuant to the application of section 1902(e)(4) (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis); or

(E) on such basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality has been previously presented.

(3)(A) For purposes of this subsection, the term “satisfactory documentary evidence of citizenship or nationality” means—

(i) any document described in subparagraph (B); or

(ii) a document described in subparagraph (C) and a document described in subparagraph (D).

- (B) The following are documents described in this subparagraph:
- (i) A United States passport.
 - (ii) Form N-550 or N-570 (Certificate of Naturalization).
 - (iii) Form N-560 or N-561 (Certificate of United States Citizenship).
 - (iv) A valid State-issued driver's license or other identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act, but only if the State issuing the license or such document requires proof of United States citizenship before issuance of such license or document or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen.
 - (v)(I) Except as provided in subclause (II), a document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).
 - (II) With respect to those federally recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection.
 - (vi) Such other document as the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.
- (C) The following are documents described in this subparagraph:
- (i) A certificate of birth in the United States.
 - (ii) Form FS-545 or Form DS-1350 (Certification of Birth Abroad).
 - (iii) Form I-197 (United States Citizen Identification Card).
 - (iv) Form FS-240 (Report of Birth Abroad of a Citizen of the United States).
 - (v) Such other document (not described in subparagraph (B)(iv)) as the Secretary may specify that provides proof of United States citizenship or nationality.
- (D) The following are documents described in this subparagraph:
- (i) Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act.
 - (ii) Any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.
- (E) A reference in this paragraph to a form includes a reference to any successor form.
- (4) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1902(a)(46)(B)(i), the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this

subsection as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.

(5) Nothing in subparagraph (A) or (B) of section 1902(a)(46), the preceding paragraphs of this subsection, or the Deficit Reduction Act of 2005, including section 6036 of such Act, shall be construed as changing the requirement of section 1902(e)(4) that a child born in the United States to an alien mother for whom medical assistance for the delivery of such child is available as treatment of an emergency medical condition pursuant to subsection (v) shall be deemed eligible for medical assistance during the first year of such child's life.

(y) PAYMENTS FOR ESTABLISHMENT OF ALTERNATE NON-EMERGENCY SERVICES PROVIDERS.—

(1) PAYMENTS.—In addition to the payments otherwise provided under subsection (a), subject to paragraph (2), the Secretary shall provide for payments to States under such subsection for the establishment of alternate non-emergency service providers (as defined in section 1916A(e)(5)(B)), or networks of such providers.

(2) LIMITATION.—The total amount of payments under this subsection shall not exceed \$50,000,000 during the 4-year period beginning with 2006. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

(3) PREFERENCE.—In providing for payments to States under this subsection, the Secretary shall provide preference to States that establish, or provide for, alternate non-emergency services providers or networks of such providers that—

(A) serve rural or underserved areas where beneficiaries under this title may not have regular access to providers of primary care services; or

(B) are in partnership with local community hospitals.

(4) FORM AND MANNER OF PAYMENT.—Payment to a State under this subsection shall be made only upon the filing of such application in such form and in such manner as the Secretary shall specify. Payment to a State under this subsection shall be made in the same manner as other payments under section 1903(a).

(z) MEDICAID TRANSFORMATION PAYMENTS.—

(1) IN GENERAL.—In addition to the payments provided under subsection (a), subject to paragraph (4), the Secretary shall provide for payments to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under this title.

(2) PERMISSIBLE USES OF FUNDS.—The following are examples of innovative methods for which funds provided under this subsection may be used:

(A) Methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs.

(B) Methods for improving rates of collection from estates of amounts owed under this title.

(C) Methods for reducing waste, fraud, and abuse under the program under this title, such as reducing improper payment rates as measured by annual payment error rate measurement (PERM) project rates.

(D) Implementation of a medication risk management program as part of a drug use review program under section 1927(g).

(E) Methods in reducing, in clinically appropriate ways, expenditures under this title for covered outpatient drugs, particularly in the categories of greatest drug utilization, by increasing the utilization of generic drugs through the use of education programs and other incentives to promote greater use of generic drugs.

(F) Methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems.

(3) APPLICATION; TERMS AND CONDITIONS.—

(A) IN GENERAL.—No payments shall be made to a State under this subsection unless the State applies to the Secretary for such payments in a form, manner, and time specified by the Secretary.

(B) TERMS AND CONDITIONS.—Such payments are made under such terms and conditions consistent with this subsection as the Secretary prescribes.

(C) ANNUAL REPORT.—Payment to a State under this subsection is conditioned on the State submitting to the Secretary an annual report on the programs supported by such payment. Such report shall include information on—

- (i) the specific uses of such payment;
- (ii) an assessment of quality improvements and clinical outcomes under such programs; and
- (iii) estimates of cost savings resulting from such programs.

(4) FUNDING.—

(A) LIMITATION ON FUNDS.—The total amount of payments under this subsection shall be equal to, and shall not exceed—

- (i) \$75,000,000 for fiscal year 2007; and
- (ii) \$75,000,000 for fiscal year 2008.

This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

(B) ALLOCATION OF FUNDS.—The Secretary shall specify a method for allocating the funds made available under this subsection among States. Such method shall provide preference for States that design programs that target health providers that treat significant numbers of Medicaid beneficiaries. Such method shall provide that not less than 25 percent of such funds shall be allocated among States the population of which (as determined according to data collected by the United States Census Bureau) as of

July 1, 2004, was more than 105 percent of the population of the respective State (as so determined) as of April 1, 2000.

(C) FORM AND MANNER OF PAYMENT.—Payment to a State under this subsection shall be made in the same manner as other payments under section 1903(a). There is no requirement for State matching funds to receive payments under this subsection.

(5) MEDICATION RISK MANAGEMENT PROGRAM.—

(A) IN GENERAL.—For purposes of this subsection, the term “medication risk management program” means a program for targeted beneficiaries that ensures that covered outpatient drugs are appropriately used to optimize therapeutic outcomes through improved medication use and to reduce the risk of adverse events.

(B) ELEMENTS.—Such program may include the following elements:

(i) The use of established principles and standards for drug utilization review and best practices to analyze prescription drug claims of targeted beneficiaries and identify outlier physicians.

(ii) On an ongoing basis provide outlier physicians—

(I) a comprehensive pharmacy claims history for each targeted beneficiary under their care;

(II) information regarding the frequency and cost of relapses and hospitalizations of targeted beneficiaries under the physician’s care; and

(III) applicable best practice guidelines and empirical references.

(iii) Monitor outlier physician’s prescribing, such as failure to refill, dosage strengths, and provide incentives and information to encourage the adoption of best clinical practices.

(C) TARGETED BENEFICIARIES.—For purposes of this paragraph, the term “targeted beneficiaries” means Medicaid eligible beneficiaries who are identified as having high prescription drug costs and medical costs, such as individuals with behavioral disorders or multiple chronic diseases who are taking multiple medications.

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 1/4 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:

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

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

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

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

(c) *TARGET TOTAL MEDICAL ASSISTANCE EXPENDITURES.*—

(1) *CALCULATION.*—In this section, the term “target total medical assistance expenditures” means, for a State for a fiscal year, 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) is not made under section 1923;

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

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

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

(iii) An expenditure described in this clause is an expenditure that meets the criteria specified in subclauses (I), (II),

and (III) of clause (ii) and is authorized under section 1115 for the purposes of funding a delivery system reform pool, uncompensated care pool, a designated state health program, or any other similar expenditure (as defined by the Secretary).

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

(C) For fiscal year 2016, the State's non-DSH supplemental 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 subclause (XII) or (XXI) of section 1902(a)(10)(A)(ii) (or pursuant to a waiver that provides only comparable benefits);

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

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

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

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

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

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

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

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

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

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

(f) *SPECIAL PAYMENT RULES.*—

(1) *APPLICATION IN CASE OF RESEARCH AND DEMONSTRATION PROJECTS AND OTHER WAIVERS.*—In the case of a State with a waiver of the State plan approved under section 1115, section 1915, or another provision of this title, this section shall apply to medical assistance expenditures and medical assistance payments under the waiver, in the same manner as if such expenditures and payments had been made under a State plan under this title and the limitations on expenditures under this section shall supersede any other payment limitations or provisions (including limitations based on a per capita limitation) otherwise applicable under such a waiver.

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

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

(A) the Secretary shall calculate and apply subsections (a) through (e) with respect to the State as if all 1903A enrollee categories for which such expenditure and enrollee data were not satisfactorily submitted were a single 1903A enrollee category; and

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

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

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

(1) *REPORTING.*—In addition to the data required on form Group VIII on the CMS-64 report form as of January 1, 2017, in each CMS-64 report required to be submitted (for each quar-

ter beginning on or after October 1, 2018), the State shall include data on medical assistance expenditures within such categories of services and categories of enrollees (including each 1903A enrollee category and each category of excluded individuals under subsection (e)(1)) and the numbers of enrollees within each of such enrollee categories, as the Secretary determines are necessary (including timely guidance published as soon as possible after the date of the enactment of this section) in order to implement this section and to enable States to comply with the requirement of this paragraph on a timely basis.

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

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

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

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

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

* * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term “medical assistance” means payment of part or all of the cost of the following care and services or the care and services themselves, or both (if provided [in or after the third month before the month in which the recipient makes application for assistance] *in or after the month in which the recipient makes application for assistance* or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or

assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

- (i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,
 - (ii) relatives specified in section 406(b)(1) with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of title IV,
 - (iii) 65 years of age or older,
 - (iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,
 - (v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,
 - (vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI,
 - (vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI,
 - (viii) pregnant women,
 - (ix) individuals provided extended benefits under section 1925,
 - (x) individuals described in section 1902(u)(1),
 - (xi) individuals described in section 1902(z)(1),
 - (xii) employed individuals with a medically improved disability (as defined in subsection (v)),
 - (xiii) individuals described in section 1902(aa),
 - (xiv) individuals described in section 1902(a)(10)(A)(i)(VIII) or 1902(a)(10)(A)(i)(IX),
 - (xv) individuals described in section 1902(a)(10)(A)(ii)(XX),
 - (xvi) individuals described in section 1902(ii), or
 - (xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection,
- but whose income and resources are insufficient to meet all of such cost—
- (1) inpatient hospital services (other than services in an institution for mental diseases);
 - (2)(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (1)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (1)(1)) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (1)(2)) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4)(A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for individuals who are eligible under the plan and are under the age of 21; (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies; and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb));

(5)(A) physicians' services furnished by a physician (as defined in section 1861(r)(1)), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1861(r)(2)) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1861(r)(1));

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services, including—

(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force;

(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and

(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum

reduction of physical or mental disability and restoration of an individual to the best possible functional level;

(14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1902(a)(31), to be in need of such care;

(16) (A) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h), and, (B) for individuals receiving services described in subparagraph (A), early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)), whether or not such screening, diagnostic, and treatment services are furnished by the provider of the services described in such subparagraph;

(17) services furnished by a nurse-midwife (as defined in section 1861(gg)) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

(18) hospice care (as defined in subsection (o));

(19) case management services (as defined in section 1915(g)(2)) and TB-related services described in section 1902(z)(2)(F);

(20) respiratory care services (as defined in section 1902(e)(9)(C));

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider;

(22) home and community care (to the extent allowed and as defined in section 1929) for functionally disabled elderly individuals;

(23) community supported living arrangements services (to the extent allowed and as defined in section 1930);

(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such

services and who is not a member of the individual's family, and (C) furnished in a home or other location;

(25) primary care case management services (as defined in subsection (t));

(26) services furnished under a PACE program under section 1934 to PACE program eligible individuals enrolled under the program under such section;

(27) subject to subsection (x), primary and secondary medical strategies and treatment and services for individuals who have Sickie Cell Disease;

(28) freestanding birth center services (as defined in subsection (1)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (1)(3)(B)) and that are otherwise included in the plan; and

(29) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary, except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of title XVIII for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under title XVIII who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency.

(b) Subject to subsections (y), (z), and (aa) and section 1933(d), the term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State

bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 55 percent, (3) for purposes of this title and title XXI, the Federal medical assistance percentage for the District of Columbia shall be 70 percent, (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 2105(b) with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII), and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4)(D). The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act). Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures (other than expenditures under section 1923) described in subsection (u)(2)(A) or subsection (u)(3) for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under section 2104, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b).

(c) For definition of the term "nursing facility", see section 1919(a).

(d) The term "intermediate care facility for the mentally retarded" means an institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—

(1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary;

(2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this title is receiving active treatment under such a program; and

(3) in the case of a public institution, the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof)

in the State will not, because of payments made under this title, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this title.

(e) In the case of any State the State plan of which (as approved under this title)—

(1) does not provide for the payment of services (other than services covered under section 1902(a)(12)) provided by an optometrist; but

(2) at a prior period did provide for the payment of services referred to in paragraph (1);

the term “physicians’ services” (as used in subsection (a)(5)) shall include services of the type which an optometrist is legally authorized to perform where the State plan specifically provides that the term “physicians’ services”, as employed in such plan, includes services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist.

(f) For purposes of this title, the term “nursing facility services” means services which are or were required to be given an individual who needs or needed on a daily basis nursing care (provided directly by or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis.

(g) If the State plan includes provision of chiropractors’ services, such services include only—

(1) services provided by a chiropractor (A) who is licensed as such by the State and (B) who meets uniform minimum standards promulgated by the Secretary under section 1861(r)(5); and

(2) services which consist of treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the State.

(h)(1) For purposes of paragraph (16) of subsection (a), the term “inpatient psychiatric hospital services for individuals under age 21” includes only—

(A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1861(f) or in another inpatient setting that the Secretary has specified in regulations;

(B) inpatient services which, in the case of any individual (i) involve active treatment which meets such standards as may be prescribed in regulations by the Secretary, and (ii) a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and

(C) inpatient services which, in the case of any individual, are provided prior to (i) the date such individual attains age

21, or (ii) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (I) the date such individual no longer requires such services, or (II) if earlier, the date such individual attains age 22;

(2) Such term does not include services provided during any calendar quarter under the State plan of any State if the total amount of the funds expended, during such quarter, by the State (and the political subdivisions thereof) from non-Federal funds for inpatient services included under paragraph (1), and for active psychiatric care and treatment provided on an outpatient basis for eligible mentally ill children, is less than the average quarterly amount of the funds expended, during the 4-quarter period ending December 31, 1971, by the State (and the political subdivisions thereof) from non-Federal funds for such services.

(i) The term "institution for mental diseases" means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(j) The term "State supplementary payment" means any cash payment made by a State on a regular basis to an individual who is receiving supplemental security income benefits under title XVI or who would but for his income be eligible to receive such benefits, as assistance based on need in supplementation of such benefits (as determined by the Commissioner of Social Security), but only to the extent that such payments are made with respect to an individual with respect to whom supplemental security income benefits are payable under title XVI, or would but for his income be payable under that title.

(k) Increased supplemental security income benefits payable pursuant to section 211 of Public Law 93-66 shall not be considered supplemental security income benefits payable under title XVI.

(l)(1) The terms "rural health clinic services" and "rural health clinic" have the meanings given such terms in section 1861(aa), except that (A) clause (ii) of section 1861(aa)(2) shall not apply to such terms, and (B) the physician arrangement required under section 1861(aa)(2)(B) shall only apply with respect to rural health clinic services and, with respect to other ambulatory care services, the physician arrangement required shall be only such as may be required under the State plan for those services.

(2)(A) The term "Federally-qualified health center services" means services of the type described in subparagraphs (A) through (C) of section 1861(aa)(1) when furnished to an individual as a patient of a Federally-qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in section 1861(aa)(2)(B) is deemed a reference to a Federally-qualified health center or a physician at the center, respectively.

(B) The term "Federally-qualified health center" means an entity which—

(i) is receiving a grant under section 330 of the Public Health Service Act,

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and

(II) meets the requirements to receive a grant under section 330 of such Act,

(iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity, or

(iv) was treated by the Secretary, for purposes of part B of title XVIII, as a comprehensive Federally funded health center as of January 1, 1990;

and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services. In applying clause (ii), the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown.

(3)(A) The term “freestanding birth center services” means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)) at such center.

(B) The term “freestanding birth center” means a health facility—

(i) that is not a hospital;

(ii) where childbirth is planned to occur away from the pregnant woman’s residence;

(iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and

(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

(C) A State shall provide separate payments to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center (as defined in subparagraph (B)), such as nurse midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Secretary. For purposes of the preceding sentence, the term “birth attendant” means an individual who is recognized or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a birth attendant.

(m)(1) Subject to paragraph (2), the term “qualified family member” means an individual (other than a qualified pregnant woman or child, as defined in subsection (n)) who is a member of a family that would be receiving aid under the State plan under part A of title IV pursuant to section 407 if the State had not exercised the option under section 407(b)(2)(B)(i).

(2) No individual shall be a qualified family member for any period after September 30, 1998.

(n) The term “qualified pregnant woman or child” means—

(1) a pregnant woman who—

(A) would be eligible for aid to families with dependent children under part A of title IV (or would be eligible for such aid if coverage under the State plan under part A of title IV included aid to families with dependent children of unemployed parents pursuant to section 407) if her child had been born and was living with her in the month such aid would be paid, and such pregnancy has been medically verified;

(B) is a member of a family which would be eligible for aid under the State plan under part A of title IV pursuant to section 407 if the plan required the payment of aid pursuant to such section; or

(C) otherwise meets the income and resources requirements of a State plan under part A of title IV; and

(2) a child who has not attained the age of 19, who was born after September 30, 1983 (or such earlier date as the State may designate), and who meets the income and resources requirements of the State plan under part A of title IV.

(o)(1)(A) Subject to subparagraphs (B) and (C), the term “hospice care” means the care described in section 1861(dd)(1) furnished by a hospice program (as defined in section 1861(dd)(2)) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to have payment made for hospice care instead of having payment made for certain benefits described in section 1812(d)(2)(A) and for which payment may otherwise be made under title XVIII and intermediate care facility services under the plan. For purposes of such election, hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.

(B) For purposes of this title, with respect to the definition of hospice program under section 1861(dd)(2), the Secretary may allow an agency or organization to make the assurance under subparagraph (A)(iii) of such section without taking into account any individual who is afflicted with acquired immune deficiency syndrome (AIDS).

(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under this title for, services that are related to the treatment of the child’s condition for which a diagnosis of terminal illness has been made.

(2) An individual’s voluntary election under this subsection —

(A) shall be made in accordance with procedures that are established by the State and that are consistent with the procedures established under section 1812(d)(2);

(B) shall be for such a period or periods (which need not be the same periods described in section 1812(d)(1)) as the State may establish; and

(C) may be revoked at any time without a showing of cause and may be modified so as to change the hospice program with respect to which a previous election was made.

(3) In the case of an individual—

(A) who is residing in a nursing facility or intermediate care facility for the mentally retarded and is receiving medical assistance for services in such facility under the plan,

(B) who is entitled to benefits under part A of title XVIII and has elected, under section 1812(d), to receive hospice care under such part, and

(C) with respect to whom the hospice program under such title and the nursing facility or intermediate care facility for the mentally retarded have entered into a written agreement under which the program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual, instead of any payment otherwise made under the plan with respect to the facility's services, the State shall provide for payment to the hospice program of an amount equal to the additional amount determined in section 1902(a)(13)(B) and, if the individual is an individual described in section 1902(a)(10)(A), shall provide for payment of any coinsurance amounts imposed under section 1813(a)(4).

(p)(1) The term “qualified medicare beneficiary” means an individual—

(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A),

(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program or, effective beginning with January 1, 2010, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1860D-14(a)(3) (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be).

(2)(A) The income level established under paragraph (1)(B) shall be at least the percent provided under subparagraph (B) (but not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(B) Except as provided in subparagraph (C), the percent provided under this clause, with respect to eligibility for medical assistance on or after—

- (i) January 1, 1989, is 85 percent,
- (ii) January 1, 1990, is 90 percent, and
- (iii) January 1, 1991, is 100 percent.

(C) In the case of a State which has elected treatment under section 1902(f) and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive than the income standard established under the supplemental security income program under title XVI, the percent provided under subparagraph (B), with respect to eligibility for medical assistance on or after—

- (i) January 1, 1989, is 80 percent,
- (ii) January 1, 1990, is 85 percent,
- (iii) January 1, 1991, is 95 percent, and
- (iv) January 1, 1992, is 100 percent.

(D)(i) In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under title II for a transition month (as defined in clause (ii)) in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such title which have occurred pursuant to section 215(i) for benefits payable for months beginning with December of the previous year.

(ii) For purposes of clause (i), the term “transition month” means each month in a year through the month following the month in which the annual revision of the official poverty line, referred to in subparagraph (A), is published.

(3) The term “medicare cost-sharing” means (subject to section 1902(n)(2)) the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

- (A)(i) premiums under section 1818 or 1818A, and
- (ii) premiums under section 1839,
- (B) Coinsurance under title XVIII (including coinsurance described in section 1813).
- (C) Deductibles established under title XVIII (including those described in section 1813 and section 1833(b)).
- (D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to “80 percent” therein were deemed a reference to “100 percent”.

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.

(4) Notwithstanding any other provision of this title, in the case of a State (other than the 50 States and the District of Columbia)—

- (A) the requirement stated in section 1902(a)(10)(E) shall be optional, and
- (B) for purposes of paragraph (2), the State may substitute for the percent provided under subparagraph (B) of such paragraph or 1902(a)(10)(E)(iii) any percent.

In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirement of section 1902(a)(10)(E) in the same manner as the State would be required

to meet such requirement if the State had in effect a plan approved under this title.

(5)(A) The Secretary shall develop and distribute to States a simplified application form for use by individuals (including both qualified medicare beneficiaries and specified low-income medicare beneficiaries) in applying for medical assistance for medicare cost-sharing under this title in the States which elect to use such form. Such form shall be easily readable by applicants and uniform nationally. The Secretary shall provide for the translation of such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under section 226 or 226A and shall make the translated forms available to the States and to the Commissioner of Social Security.

(B) In developing such form, the Secretary shall consult with beneficiary groups and the States.

(6) For provisions relating to outreach efforts to increase awareness of the availability of medicare cost-sharing, see section 1144.

(q) The term "qualified severely impaired individual" means an individual under age 65—

(1) who for the month preceding the first month to which this subsection applies to such individual—

(A) received (i) a payment of supplemental security income benefits under section 1611(b) on the basis of blindness or disability, (ii) a supplementary payment under section 1616 of this Act or under section 212 of Public Law 93-66 on such basis, (iii) a payment of monthly benefits under section 1619(a), or (iv) a supplementary payment under section 1616(c)(3), and

(B) was eligible for medical assistance under the State plan approved under this title; and

(2) with respect to whom the Commissioner of Social Security determines that—

(A) the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under title XVI,

(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments),

(C) the lack of eligibility for benefits under this title would seriously inhibit his ability to continue or obtain employment, and

(D) the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under title XVI (including any federally administered State supplementary payments), this title, and publicly funded attendant care services (including personal care assistance) that would be available to him in the absence of such earnings.

In the case of an individual who is eligible for medical assistance pursuant to section 1619(b) in June, 1987, the individual shall be a qualified severely impaired individual for so long as such individual meets the requirements of paragraph (2).

(r) The term “early and periodic screening, diagnostic, and treatment services” means the following items and services:

(1) Screening services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

(B) which shall at a minimum include—

(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

(ii) a comprehensive unclothed physical exam,

(iii) appropriate immunizations (according to the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines) according to age and health history,

(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

(v) health education (including anticipatory guidance).

(2) Vision services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services—

(A) which are provided—

(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this title in early and periodic screening, diagnostic, and treatment services.

(s) The term “qualified disabled and working individual” means an individual—

(1) who is entitled to enroll for hospital insurance benefits under part A of title XVIII under section 1818A (as added by 6012 of the Omnibus Budget Reconciliation Act of 1989);

(2) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 200 percent of the official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;

(3) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits for supplemental security income benefits under title XVI; and

(4) who is not otherwise eligible for medical assistance under this title.

(t)(1) The term “primary care case management services” means case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

(2) The term “primary care case manager” means any of the following that provides services of the type described in paragraph (1) under a contract referred to in such paragraph:

(A) A physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services.

(B) At State option—

(i) a nurse practitioner (as described in section 1905(a)(21));

(ii) a certified nurse-midwife (as defined in section 1861(gg)); or

(iii) a physician assistant (as defined in section 1861(aa)(5)).

(3) The term “primary care case management contract” means a contract between a primary care case manager and a State under which the manager undertakes to locate, coordinate, and monitor covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the manager, and which—

(A) provides for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

(B) restricts enrollment to individuals residing sufficiently near a service delivery site of the manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;

(C) provides for arrangements with, or referrals to, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

(D) prohibits discrimination on the basis of health status or requirements for health care services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this title;

(E) provides for a right for an enrollee to terminate enrollment in accordance with section 1932(a)(4); and

(F) complies with the other applicable provisions of section 1932.

(4) For purposes of this subsection, the term “primary care” includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

(u)(1) The conditions described in this paragraph for a State plan are as follows:

(A) The State is complying with the requirement of section 2105(d)(1).

(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out the fourth sentence of subsection (b).

(2)(A) For purposes of subsection (b), the expenditures described in this subparagraph are expenditures for medical assistance for optional targeted low-income children described in subparagraph (B).

(B) For purposes of this paragraph, the term “optional targeted low-income child” means a targeted low-income child as defined in section 2110(b)(1) (determined without regard to that portion of subparagraph (C) of such section concerning eligibility for medical assistance under this title) who would not qualify for medical assistance under the State plan under this title as in effect on March 31, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1902(l)(1)(D)). Such term excludes any child eligible for medical assistance only by reason of section 1902(a)(10)(A)(ii)(XIX).

(3) For purposes of subsection (b), the expenditures described in this paragraph are expenditures for medical assistance for children who are born before October 1, 1983, and who would be described in section 1902(l)(1)(D) if they had been born on or after such date, and who are not eligible for such assistance under the State plan under this title based on such State plan as in effect as of March 31, 1997.

(4) The limitations on payment under subsections (f) and (g) of section 1108 shall not apply to Federal payments made under section 1903(a)(1) based on an enhanced FMAP described in section 2105(b).

(v)(1) The term “employed individual with a medically improved disability” means an individual who—

(A) is at least 16, but less than 65, years of age;

(B) is employed (as defined in paragraph (2));

(C) ceases to be eligible for medical assistance under section 1902(a)(10)(A)(ii)(XV) because the individual, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be eligible for benefits under section 223(d) or 1614(a)(3); and

(D) continues to have a severe medically determinable impairment, as determined under regulations of the Secretary.

(2) For purposes of paragraph (1), an individual is considered to be “employed” if the individual—

(A) is earning at least the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act (29 U.S.C. 206) and working at least 40 hours per month; or

(B) is engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined by the State and approved by the Secretary.

(w)(1) For purposes of this title, the term “independent foster care adolescent” means an individual—

(A) who is under 21 years of age;

(B) who, on the individual’s 18th birthday, was in foster care under the responsibility of a State; and

(C) whose assets, resources, and income do not exceed such levels (if any) as the State may establish consistent with paragraph (2).

(2) The levels established by a State under paragraph (1)(C) may not be less than the corresponding levels applied by the State under section 1931(b).

(3) A State may limit the eligibility of independent foster care adolescents under section 1902(a)(10)(A)(ii)(XVII) to those individ-

uals with respect to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of title IV before the date the individuals attained 18 years of age.

(x) For purposes of subsection (a)(27), the strategies, treatment, and services described in that subsection include the following:

(1) Chronic blood transfusion (with deferoxamine chelation) to prevent stroke in individuals with Sickle Cell Disease who have been identified as being at high risk for stroke.

(2) Genetic counseling and testing for individuals with Sickle Cell Disease or the sickle cell trait to allow health care professionals to treat such individuals and to prevent symptoms of Sickle Cell Disease.

(3) Other treatment and services to prevent individuals who have Sickle Cell Disease and who have had a stroke from having another stroke.

(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

(1) AMOUNT OF INCREASE.—Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, [with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be] *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 equal to—*

(A) 100 percent for calendar quarters in 2014, 2015, and 2016;

(B) 95 percent for calendar quarters in 2017;

(C) 94 percent for calendar quarters in 2018;

(D) 93 percent for calendar quarters in 2019; and

(E) 90 percent for calendar quarters in 2020 and each year thereafter.

(2) DEFINITIONS.—In this subsection:

(A) NEWLY ELIGIBLE.—The term “newly eligible” means, with respect to an individual described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, as of December 1, 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligi-

ble but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

(B) FULL BENEFITS.—The term “full benefits” means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i).

(z) EQUITABLE SUPPORT FOR CERTAIN STATES.—

(1)(A) During the period that begins on January 1, 2014, and ends on December 31, 2015, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to a fiscal year occurring during that period shall be increased by 2.2 percentage points for any State described in subparagraph (B) for amounts expended for medical assistance for individuals who are not newly eligible (as defined in subsection (y)(2)) individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).

(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

- (i) is an expansion State described in paragraph (3);
- (ii) the Secretary determines will not receive any payments under this title on the basis of an increased Federal medical assistance percentage under subsection (y) for expenditures for medical assistance for newly eligible individuals (as so defined); and
- (iii) has not been approved by the Secretary to divert a portion of the DSH allotment for a State to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.

(2)(A) For calendar quarters in 2014 and each year thereafter, the Federal medical assistance percentage otherwise determined under subsection (b) for an expansion State described in paragraph (3) with respect to **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 shall be** *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 equal to the percent specified in subparagraph (B)(i) for such year.

(B)(i) The percent specified in this subparagraph for a State for a year is equal to the Federal medical assistance percentage (as defined in the first sentence of subsection (b)) for the State increased by a number of percentage points equal to the transition percentage (specified in clause (ii) for the year) of the number of percentage points by which—

(I) such Federal medical assistance percentage for the State, is less than

(II) the percent specified in subsection (y)(1) for the year.

(ii) The transition percentage specified in this clause for—

(I) 2014 is 50 percent;

(II) 2015 is 60 percent;

(III) 2016 is 70 percent; *and*

[(IV) 2017 is 80 percent;

[(V) 2018 is 90 percent; and

[(VI) 2019 and each subsequent year is 100 percent.]

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

(3) A State is an expansion State if, on the date of the enactment of the Patient Protection and Affordable Care Act, the State offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that includes inpatient hospital services, is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1938. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

(aa)(1) Notwithstanding subsection (b), beginning January 1, 2011, the Federal medical assistance percentage for a fiscal year for a disaster-recovery FMAP adjustment State shall be equal to the following:

(A) In the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the State's regular FMAP shall be increased by 50 percent of the number of percentage points by which the State's regular FMAP for such fiscal year is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111-5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsections (y) and (z), and subsections (b) and (c) of section 5001 of Public Law 111-5.

(B) In the case of the second or any succeeding fiscal year for which this subsection applies to the State, the State's regular FMAP for such fiscal year shall be increased by 25 percent (or 50 percent in the case of fiscal year 2013) of the number of percentage points by which the State's regular FMAP for such fiscal year is less than the Federal medical assistance percentage received by the State during the preceding fiscal year.

(2) In this subsection, the term “disaster-recovery FMAP adjustment State” means a State that is one of the 50 States or the District of Columbia, for which, at any time during the preceding 7 fiscal years, the President has declared a major disaster under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act and determined as a result of such disaster that every county or parish in the State warrant individual and public assistance or public assistance from the Federal Government under such Act and for which—

(A) in the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the State’s regular FMAP for the fiscal year is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsections (y) and (z), and subsections (b) and (c) of section 5001 of Public Law 111–5, by at least 3 percentage points; and

(B) in the case of the second or any succeeding fiscal year for which this subsection applies to the State, the State’s regular FMAP for the fiscal year is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection by at least 3 percentage points.

(3) In this subsection, the term “regular FMAP” means, for each fiscal year for which this subsection applies to a State, the Federal medical assistance percentage that would otherwise apply to the State for the fiscal year, as determined under subsection (b) and without regard to this subsection, subsections (y) and (z), and section 10202 of the Patient Protection and Affordable Care Act.

(4) The Federal medical assistance percentage determined for a disaster-recovery FMAP adjustment State under paragraph (1) shall apply for purposes of this title (other than with respect to disproportionate share hospital payments described in section 1923 and payments under this title that are based on the enhanced FMAP described in 2105(b)) and shall not apply with respect to payments under title IV (other than under part E of title IV) or payments under title XXI.

(bb)(1) For purposes of this title, the term “counseling and pharmacotherapy for cessation of tobacco use by pregnant women” means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and non-prescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use that is furnished—

(A) by or under the supervision of a physician; or

(B) by any other health care professional who—

(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

(ii) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose.

(2) Subject to paragraph (3), such term is limited to—

(A) services recommended with respect to pregnant women in “Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline”, published by the Public Health Service in May 2008, or any subsequent modification of such Guideline; and

(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women.

(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.

(cc) REQUIREMENT FOR CERTAIN STATES.—Notwithstanding subsections (y), (z), and (aa), in the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures required under the State plan under section 1902(a)(2), the State shall not be eligible for an increase in its Federal medical assistance percentage under such subsections if it requires that political subdivisions pay a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1923, than the respective percentages that would have been required by the State under the State plan under this title, State law, or both, as in effect on December 31, 2009, and without regard to any such increase. Voluntary contributions by a political subdivision to the non-Federal share of expenditures under the State plan under this title or to the non-Federal share of payments under section 1923, shall not be considered to be required contributions for purposes of this subsection. The treatment of voluntary contributions, and the treatment of contributions required by a State under the State plan under this title, or State law, as provided by this subsection, shall also apply to the increases in the Federal medical assistance percentage under section 5001 of the American Recovery and Reinvestment Act of 2009.

(dd) INCREASED FMAP FOR ADDITIONAL EXPENDITURES FOR PRIMARY CARE SERVICES.—Notwithstanding subsection (b), with respect to the portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2013, and before January 1, 2015, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to such services under the State plan as of July 1, 2009, the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia shall be equal to 100 percent. The preceding sentence does not prohibit the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified in such sentence.

* * * * *

PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN
REQUIREMENTS OF THIS TITLE

SEC. 1915. (a) A State shall not be deemed to be out of compliance with the requirements of paragraphs (1), (10), or (23) of section 1902(a) solely by reason of the fact that the State (or any political subdivision thereof)—

(1) has entered into—

(A) a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic; or

(B) arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1905(a)(3) or medical devices if the Secretary has found that—

(i) adequate services or devices will be available under such arrangements, and

(ii) any such laboratory services will be provided only through laboratories—

(I) which meet the applicable requirements of section 1861(e)(9) or paragraphs (16) and (17) of section 1861(s), and such additional requirements as the Secretary may require, and

(II) no more than 75 percent of whose charges for such services are for services provided to individuals who are entitled to benefits under this title or under part A or part B of title XVIII; or

(2) restricts for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if—

(A) the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), and

(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.

(b) The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this title, may waive such requirements of section 1902 (other than subsection (s)) (other than sections 1902(a)(15), 1902(bb), and 1902(a)(10)(A) insofar as it requires provision of the care and services described in section 1905(a)(2)(C)) as may be necessary for a State—

(1) to implement a primary care case-management system or a specialty physician services arrangement which restricts the

provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain medical care services (other than in emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary,

(2) to allow a locality to act as a central broker in assisting individuals (eligible for medical assistance under this title) in selecting among competing health care plans, if such restriction does not substantially impair access to services of adequate quality where medically necessary,

(3) to share (through provision of additional services) with recipients of medical assistance under the State plan cost savings resulting from use by the recipient of more cost-effective medical care, and

(4) to restrict the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain services (other than in emergency circumstances) to providers or practitioners who undertake to provide such services and who meet, accept, and comply with the reimbursement, quality, and utilization standards under the State plan, which standards shall be consistent with the requirements of section 1923 and are consistent with access, quality, and efficient and economic provision of covered care and services, if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under section 1902(a)(37)(A).

No waiver under this subsection may restrict the choice of the individual in receiving services under section 1905(a)(4)(C). Subsection (h)(2) shall apply to a waiver under this subsection.

(c)(1) The Secretary may by waiver provide that a State plan approved under this title may include as “medical assistance” under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term “room and board” shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver

and to assure financial accountability for funds expended with respect to such services;

(B) the State will provide, with respect to individuals who—

(i) are entitled to medical assistance for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based care under such waiver,

for an evaluation of the need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(C) such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(E) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community). A waiver under this subsection (other than a waiver described in subsection (h)(2)) shall be for an initial term of three years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.

(4) A waiver granted under this subsection may, consistent with paragraph (2)—

(A) limit the individuals provided benefits under such waiver to individuals with respect to whom the State has determined that there is a reasonable expectation that the amount of med-

ical assistance provided with respect to the individual under such waiver will not exceed the amount of such medical assistance provided for such individual if the waiver did not apply, and

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, home-maker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

Except as provided under paragraph (2)(D), the Secretary may not restrict the number of hours or days of respite care in any period which a State may provide under a waiver under this subsection.

(5) For purposes of paragraph (4)(B), the term “habilitation services”—

(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and

(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services; but

(C) does not include—

(i) special education and related services (as such terms are defined in section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401)) which otherwise are available to the individual through a local educational agency; and

(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to services under such a waiver on the ground that, in order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.

(7)(A) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with a particular illness or condition who are inpatients in, or who would require the level of care provided in, hospitals, nursing facilities, or intermediate care facilities for the mentally retarded, the State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients in,

or who would require the level of care provided in, those respective facilities.

(B) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with developmental disabilities who are inpatients in a nursing facility and whom the State has determined, on the basis of an evaluation under paragraph (2)(B), to need the level of services provided by an intermediate care facility for the mentally retarded, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals under the State plan on the basis of the average per capita expenditures under the State plan for services to individuals who are inpatients in an intermediate care facility for the mentally retarded, without regard to the availability of beds for such inpatients.

(C) In making estimates under paragraph (2)(D) in the case of a waiver to the extent that it applies to individuals with mental retardation or a related condition who are resident in an intermediate care facility for the mentally retarded the participation of which under the State plan is terminated, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals without regard to any such termination.

(8) The State agency administering the plan under this title may, whenever appropriate, enter into cooperative arrangements with the State agency responsible for administering the program for children with special health care needs under title V in order to assure improved access to coordinated services to meet the needs of such children.

(9) In the case of any waiver under this subsection which contains a limit on the number of individuals who shall receive home or community-based services, the State may substitute additional individuals to receive such services to replace any individuals who die or become ineligible for services under the State plan.

(10) The Secretary shall not limit to fewer than 200 the number of individuals in the State who may receive home and community-based services under a waiver under this subsection.

(d)(1) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this title shall include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) which are provided pursuant to a written plan of care to individuals 65 years of age or older with respect to whom there has been a determination that but for the provision of such services the individuals would be likely to require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term "room and board" shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) with respect to individuals 65 years of age or older who—

(i) are entitled to medical assistance for skilled nursing or intermediate care facility services under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based services under such waiver,

the State will provide for an evaluation of the need for such skilled nursing facility or intermediate care facility services; and

(C) such individuals who are determined to be likely to require the level of care provided in a skilled nursing facility or intermediate care facility are informed of the feasible alternatives to the provision of skilled nursing facility or intermediate care facility services, which such individuals may choose if available under the waiver.

Each State with a waiver under this subsection shall provide to the Secretary annually, consistent with a reasonable data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community). Subject to a termination by the State (with notice to the Secretary) at any time, a waiver under this subsection (other than a waiver described in subsection (h)(2)) shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under the waiver, that the maximum amount of the individual's income which may be disregarded for any month is equal to the amount that may be allowed for that purpose under a waiver under subsection (c).

(4) A waiver under this subsection may, consistent with paragraph (2), provide medical assistance to individuals for case management services, homemaker/home health aide services and personal care services, adult day health services, respite care, and other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based care setting.

(5)(A) In the case of a State having a waiver approved under this subsection, notwithstanding any other provision of section 1903 to the contrary, the total amount expended by the State for medical

assistance with respect to skilled nursing facility services, intermediate care facility services, and home and community-based services under the State plan for individuals 65 years of age or older during a waiver year under this subsection may not exceed the projected amount determined under subparagraph (B).

(B) For purposes of subparagraph (A), the projected amount under this subparagraph is the sum of the following:

(i) The aggregate amount of the State's medical assistance under this title for skilled nursing facility services and intermediate care facility services furnished to individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(ii) The aggregate amount of the State's medical assistance under this title for home and community-based services for individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(iii) The Secretary shall develop and promulgate by regulation (by not later than October 1, 1989)—

(I) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise both skilled nursing facility services and intermediate care facility services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (i)(I);

(II) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of

goods and services which comprise home and community-based services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (ii)(I); and

(III) a method for projecting, on a State specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period.

The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period. Effective on and after the date the Secretary promulgates the regulation under clause (iii), any reference in this subparagraph to the "lesser of 7 percent" shall be deemed to be a reference to the "greater of 7 percent".

(iv) If there is enacted after December 22, 1987, an Act which amends this title whose provisions become effective on or after such date and which results in an increase in the aggregate amount of medical assistance under this title for nursing facility services and home and community-based services for individuals who have attained the age of 65 years, the Secretary, at the request of a State with a waiver under this subsection for a waiver year or years and in close consultation with the State, shall adjust the projected amount computed under this subparagraph for the waiver year or years to take into account such increase.

(C) In this paragraph:

(i) The term "home and community-based services" includes services described in sections 1905(a)(7) and 1905(a)(8), services described in subsection (c)(4)(B), services described in paragraph (4), and personal care services.

(ii)(I) Subject to subclause (II), the term "base year" means the most recent year (ending before the date of the enactment of this subsection) for which actual final expenditures under this title have been reported to, and accepted by, the Secretary.

(II) For purposes of subparagraph (C), in the case of a State that does not report expenditures on the basis of the age categories described in such subparagraph for a year ending before the date of the enactment of this subsection, the term "base year" means fiscal year 1989.

(iii) The term "intermediate care facility services" does not include services furnished in an institution certified in accordance with section 1905(d).

(6)(A) A determination by the Secretary to deny a request for a waiver (or extension of waiver) under this subsection shall be subject to review to the extent provided under section 1116(b).

(B) Notwithstanding any other provision of this Act, if the Secretary denies a request of the State for an extension of a waiver under this subsection, any waiver under this subsection in effect on the date such request is made shall remain in effect for a period of not less than 90 days after the date on which the Secretary denies such request (or, if the State seeks review of such determination in accordance with subparagraph (A), the date on which a final determination is made with respect to such review).

(e)(1)(A) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this title shall

include as “medical assistance” under such plan payment for part or all of the cost of nursing care, respite care, physicians’ services, prescribed drugs, medical devices and supplies, transportation services, and such other services requested by the State as the Secretary may approve which are provided pursuant to a written plan of care to a child described in subparagraph (B) with respect to whom there has been a determination that but for the provision of such services the infants would be likely to require the level of care provided in a hospital or nursing facility the cost of which could be reimbursed under the State plan.

(B) Children described in this subparagraph are individuals under 5 years of age who—

(i) at the time of birth were infected with (or tested positively for) the etiologic agent for acquired immune deficiency syndrome (AIDS),

(ii) have such syndrome, or

(iii) at the time of birth were dependent on heroin, cocaine, or phencyclidine,

and with respect to whom adoption or foster care assistance is (or will be) made available under part E of title IV.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(C) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability). A waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met.

(4) The provisions of paragraph (6) of subsection (d) shall apply to this subsection in the same manner as it applies to subsection (d).

(f)(1) The Secretary shall monitor the implementation of waivers granted under this section to assure that the requirements for such waiver are being met and shall, after notice and opportunity for a

hearing, terminate any such waiver where he finds noncompliance has occurred.

(2) A request to the Secretary from a State for approval of a proposed State plan or plan amendment or a waiver of a requirement of this title submitted by the State pursuant to a provision of this title shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(g)(1) A State may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B). The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1902(a)(23). A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS), or with AIDS-related conditions, or with either, or to individuals described in section 1902(z)(1)(A) and a State may limit the provision of case management services under this subsection to individuals with chronic mental illness. The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.

(2) For purposes of this subsection:

(A)(i) The term “case management services” means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

(ii) Such term includes the following:

(I) Assessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following:

(aa) Taking client history.

(bb) Identifying the needs of the individual, and completing related documentation.

(cc) Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.

(II) Development of a specific care plan based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual’s authorized health care deci-

sion maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual.

(III) Referral and related activities to help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

(IV) Monitoring and followup activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as—

(aa) whether services are being furnished in accordance with an individual's care plan;

(bb) whether the services in the care plan are adequate; and

(cc) whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

(iii) Such term does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred, including, with respect to the direct delivery of foster care services, services such as (but not limited to) the following:

(I) Research gathering and completion of documentation required by the foster care program.

(II) Assessing adoption placements.

(III) Recruiting or interviewing potential foster care parents.

(IV) Serving legal papers.

(V) Home investigations.

(VI) Providing transportation.

(VII) Administering foster care subsidies.

(VIII) Making placement arrangements.

(B) The term "targeted case management services" are case management services that are furnished without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B) to specific classes of individuals or to individuals who reside in specified areas.

(3) With respect to contacts with individuals who are not eligible for medical assistance under the State plan or, in the case of targeted case management services, individuals who are eligible for such assistance but are not part of the target population specified in the State plan, such contacts—

(A) are considered an allowable case management activity, when the purpose of the contact is directly related to the management of the eligible individual's care; and

(B) are not considered an allowable case management activity if such contacts relate directly to the identification and management of the noneligible or nontargeted individual's needs and care.

(4)(A) In accordance with section 1902(a)(25), Federal financial participation only is available under this title for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.

(B) A State shall allocate the costs of any part of such services which are reimbursable under another federally funded program in accordance with OMB Circular A-87 (or any related or successor guidance or regulations regarding allocation of costs among federally funded programs) under an approved cost allocation program.

(5) Nothing in this subsection shall be construed as affecting the application of rules with respect to third party liability under programs, or activities carried out under title XXVI of the Public Health Service Act or by the Indian Health Service.

(h)(1) No waiver under this section (other than a waiver under subsection (c), (d), or (e), or a waiver described in paragraph (2)) may extend over a period of longer than two years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(2)(A) Notwithstanding subsections (c)(3) and (d) (3), any waiver under subsection (b), (c), or (d), or a waiver under section 1115, that provides medical assistance for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled in addition to dual eligible individuals) may be conducted for a period of 5 years and, upon the request of the State, may be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

(B) In this paragraph, the term "dual eligible individual" means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and is eligible for medical assistance under the State plan under this title or under a waiver of such plan.

(i) STATE PLAN AMENDMENT OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND DISABLED INDIVIDUALS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based services (within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has

the authority to approve a waiver and not including room and board) for individuals eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)), without determining that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, but only if the State meets the following requirements:

(A) NEEDS-BASED CRITERIA FOR ELIGIBILITY FOR, AND RECEIPT OF, HOME AND COMMUNITY-BASED SERVICES.—The State establishes needs-based criteria for determining an individual's eligibility under the State plan for medical assistance for such home and community-based services, and if the individual is eligible for such services, the specific home and community-based services that the individual will receive.

(B) ESTABLISHMENT OF MORE STRINGENT NEEDS-BASED ELIGIBILITY CRITERIA FOR INSTITUTIONALIZED CARE.—The State establishes needs-based criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan that are more stringent than the needs-based criteria established under subparagraph (A) for determining eligibility for home and community-based services.

(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.

(D) CRITERIA BASED ON INDIVIDUAL ASSESSMENT.—

(i) IN GENERAL.—The criteria established by the State for purposes of subparagraphs (A) and (B) requires an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

(ii) ADJUSTMENT AUTHORITY.—The State plan amendment provides the State with the option to modify the criteria established under subparagraph (A) (without having to obtain prior approval from the Secretary) in the event that the enrollment of individuals eligible for home and community-based services exceeds the projected enrollment submitted for purposes of subparagraph (C), but only if—

(I) the State provides at least 60 days notice to the Secretary and the public of the proposed modification;

(II) the State deems an individual receiving home and community-based services on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria; and

(III) after the effective date of such modification, the State, at a minimum, applies the criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan which applied prior to the application of the more stringent criteria developed under subparagraph (B).

(E) INDEPENDENT EVALUATION AND ASSESSMENT.—

(i) ELIGIBILITY DETERMINATION.—The State uses an independent evaluation for making the determinations described in subparagraphs (A) and (B).

(ii) ASSESSMENT.—In the case of an individual who is determined to be eligible for home and community-based services, the State uses an independent assessment, based on the needs of the individual to—

(I) determine a necessary level of services and supports to be provided, consistent with an individual's physical and mental capacity;

(II) prevent the provision of unnecessary or inappropriate care; and

(III) establish an individualized care plan for the individual in accordance with subparagraph (G).

(F) ASSESSMENT.—The independent assessment required under subparagraph (E)(ii) shall include the following:

(i) An objective evaluation of an individual's inability to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.

(ii) A face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for home and community-based services.

(iii) Where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual.

(iv) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

(v) An examination of the individual's relevant history, medical records, and care and support needs, guided by best practices and research on effective strategies that result in improved health and quality of life outcomes.

(vi) If the State offers individuals the option to self-direct the purchase of, or control the receipt of, home and community-based service, an evaluation of the ability of the individual or the individual's representative to self-direct the purchase of, or control the receipt of, such services if the individual so elects.

(G) INDIVIDUALIZED CARE PLAN.—

(i) IN GENERAL.—In the case of an individual who is determined to be eligible for home and community-based services, the State uses the independent assessment required under subparagraph (E)(ii) to establish a written individualized care plan for the individual.

(ii) PLAN REQUIREMENTS.—The State ensures that the individualized care plan for an individual—

(I) is developed—

(aa) in consultation with the individual, the individual's treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and, where appropriate the individual's family, caregiver, or representative; and

(bb) taking into account the extent of, and need for, any family or other supports for the individual;

(II) identifies the necessary home and community-based services to be furnished to the individual (or, if the individual elects to self-direct the purchase of, or control the receipt of, such services, funded for the individual); and

(III) is reviewed at least annually and as needed when there is a significant change in the individual's circumstances.

(iii) STATE OPTION TO OFFER ELECTION FOR SELF-DIRECTED SERVICES.—

(I) INDIVIDUAL CHOICE.—At the option of the State, the State may allow an individual or the individual's representative to elect to receive self-directed home and community-based services in a manner which gives them the most control over such services consistent with the individual's abilities and the requirements of subclauses (II) and (III).

(II) SELF-DIRECTED SERVICES.—The term “self-directed” means, with respect to the home and community-based services offered under the State plan amendment, such services for the individual

which are planned and purchased under the direction and control of such individual or the individual's authorized representative, including the amount, duration, scope, provider, and location of such services, under the State plan consistent with the following requirements:

(aa) ASSESSMENT.—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

(bb) SERVICE PLAN.—Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that satisfies the requirements of subclause (III).

(III) PLAN REQUIREMENTS.—For purposes of subclause (II)(bb), the requirements of this subclause are that the plan—

(aa) specifies those services which the individual or the individual's authorized representative would be responsible for directing;

(bb) identifies the methods by which the individual or the individual's authorized representative will select, manage, and dismiss providers of such services;

(cc) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

(dd) is developed through a person-centered process that is directed by the individual or the individual's authorized representative, builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities, and involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

(ee) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

(ff) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

(IV) BUDGET PROCESS.—With respect to individualized budgets described in subclause (III)(ff), the State plan amendment—

(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

(bb) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

(cc) provides a procedure to evaluate expenditures under such budgets.

(H) QUALITY ASSURANCE; CONFLICT OF INTEREST STANDARDS.—

(i) QUALITY ASSURANCE.—The State ensures that the provision of home and community-based services meets Federal and State guidelines for quality assurance.

(ii) CONFLICT OF INTEREST STANDARDS.—The State establishes standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest.

(I) REDETERMINATIONS AND APPEALS.—The State allows for at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

(J) PRESUMPTIVE ELIGIBILITY FOR ASSESSMENT.—The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for home and community-based services. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (E) to determine an individual's eligibility for such services and if the individual is so eligible, the specific home and community-based services that the individual will receive.

(2) DEFINITION OF INDIVIDUAL'S REPRESENTATIVE.—In this section, the term "individual's representative" means, with respect to an individual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

(3) NONAPPLICATION.—A State may elect in the State plan amendment approved under this section to not comply with the requirements of section 1902(a)(10)(B) (relating to comparability) and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community), but only for purposes of provided home and community-based services in accordance with such amendment. Any such election shall not be construed to apply to the provision of services to an individual receiving medical assistance in an institutionalized setting as a result of a determination that the individual requires

the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded.

(4) NO EFFECT ON OTHER WAIVER AUTHORITY.—Nothing in this subsection shall be construed as affecting the option of a State to offer home and community-based services under a waiver under subsections (c) or (d) of this section or under section 1115.

(5) CONTINUATION OF FEDERAL FINANCIAL PARTICIPATION FOR MEDICAL ASSISTANCE PROVIDED TO INDIVIDUALS AS OF EFFECTIVE DATE OF STATE PLAN AMENDMENT.—Notwithstanding paragraph (1)(B), Federal financial participation shall continue to be available for an individual who is receiving medical assistance in an institutionalized setting, or home and community-based services provided under a waiver under this section or section 1115 that is in effect as of the effective date of the State plan amendment submitted under this subsection, as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, without regard to whether such individuals satisfy the more stringent eligibility criteria established under that paragraph, until such time as the individual is discharged from the institution or waiver program or no longer requires such level of care.

(6) STATE OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES TO INDIVIDUALS ELIGIBLE FOR SERVICES UNDER A WAIVER.—

(A) IN GENERAL.—A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1115 to provide such services, but only for those individuals whose income does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1).

(B) APPLICATION OF SAME REQUIREMENTS FOR INDIVIDUALS SATISFYING NEEDS-BASED CRITERIA.—Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).

(C) AUTHORITY TO OFFER DIFFERENT TYPE, AMOUNT, DURATION, OR SCOPE OF HOME AND COMMUNITY-BASED SERVICES.—A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-

based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and do not include room or board.

(7) STATE OPTION TO OFFER HOME AND COMMUNITY-BASED SERVICES TO SPECIFIC, TARGETED POPULATIONS.—

(A) IN GENERAL.—A State may elect in a State plan amendment under this subsection to target the provision of home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.

(B) 5-YEAR TERM.—

(i) IN GENERAL.—An election by a State under this paragraph shall be for a period of 5 years.

(ii) PHASE-IN OF SERVICES AND ELIGIBILITY PERMITTED DURING INITIAL 5-YEAR PERIOD.—A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.

(C) RENEWAL.—An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning of each such renewal period, that the State has—

(i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and

(ii) met the State's objectives with respect to quality improvement and beneficiary outcomes.

(j)(1) A State may provide, as “medical assistance”, payment for part or all of the cost of self-directed personal assistance services (other than room and board) under the plan which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under the plan, or home and community-based services provided pursuant to a waiver under subsection (c). Self-directed personal assistance services may not be provided under this subsection to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

(2) The Secretary shall not grant approval for a State self-directed personal assistance services program under this section unless the State provides assurances satisfactory to the Secretary of the following:

(A) Necessary safeguards have been taken to protect the health and welfare of individuals provided services under the

program, and to assure financial accountability for funds expended with respect to such services.

(B) The State will provide, with respect to individuals who—

(i) are entitled to medical assistance for personal care services under the plan, or receive home and community-based services under a waiver granted under subsection (c);

(ii) may require self-directed personal assistance services; and

(iii) may be eligible for self-directed personal assistance services,

an evaluation of the need for personal care under the plan, or personal services under a waiver granted under subsection (c).

(C) Such individuals who are determined to be likely to require personal care under the plan, or home and community-based services under a waiver granted under subsection (c) are informed of the feasible alternatives, if available under the State's self-directed personal assistance services program, at the choice of such individuals, to the provision of personal care services under the plan, or personal assistance services under a waiver granted under subsection (c).

(D) The State will provide for a support system that ensures participants in the self-directed personal assistance services program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets. Additional counseling and management support may be provided at the request of the participant.

(E) The State will provide to the Secretary an annual report on the number of individuals served and total expenditures on their behalf in the aggregate. The State shall also provide an evaluation of overall impact on the health and welfare of participating individuals compared to non-participants every three years.

(3) A State may provide self-directed personal assistance services under the State plan without regard to the requirements of section 1902(a)(1) and may limit the population eligible to receive these services and limit the number of persons served without regard to section 1902(a)(10)(B).

(4)(A) For purposes of this subsection, the term "self-directed personal assistance services" means personal care and related services, or home and community-based services otherwise available under the plan under this title or subsection (c), that are provided to an eligible participant under a self-directed personal assistance services program under this section, under which individuals, within an approved self-directed services plan and budget, purchase personal assistance and related services, and permits participants to hire, fire, supervise, and manage the individuals providing such services.

(B) At the election of the State—

(i) a participant may choose to use any individual capable of providing the assigned tasks including legally liable relatives as paid providers of the services; and

(ii) the individual may use the individual's budget to acquire items that increase independence or substitute (such as a

microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

(5) For purpose of this section, the term “approved self-directed services plan and budget” means, with respect to a participant, the establishment of a plan and budget for the provision of self-directed personal assistance services, consistent with the following requirements:

(A) SELF-DIRECTION.—The participant (or in the case of a participant who is a minor child, the participant’s parent or guardian, or in the case of an incapacitated adult, another individual recognized by State law to act on behalf of the participant) exercises choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider, and location of service provision.

(B) ASSESSMENT OF NEEDS.—There is an assessment of the needs, strengths, and preferences of the participants for such services.

(C) SERVICE PLAN.—A plan for such services (and supports for such services) for the participant has been developed and approved by the State based on such assessment through a person-centered process that—

(i) builds upon the participant’s capacity to engage in activities that promote community life and that respects the participant’s preferences, choices, and abilities; and

(ii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the participant.

(D) SERVICE BUDGET.—A budget for such services and supports for the participant has been developed and approved by the State based on such assessment and plan and on a methodology that uses valid, reliable cost data, is open to public inspection, and includes a calculation of the expected cost of such services if those services were not self-directed. The budget may not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

(E) APPLICATION OF QUALITY ASSURANCE AND RISK MANAGEMENT.—There are appropriate quality assurance and risk management techniques used in establishing and implementing such plan and budget that recognize the roles and responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan and budget based upon the participant’s resources and capabilities.

(6) A State may employ a financial management entity to make payments to providers, track costs, and make reports under the program. Payment for the activities of the financial management entity shall be at the administrative rate established in section 1903(a).

(k) STATE PLAN OPTION TO PROVIDE HOME AND COMMUNITY-BASED ATTENDANT SERVICES AND SUPPORTS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, beginning October 1, 2011, a State may provide

through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)) or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and with respect to whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan, but only if the individual chooses to receive such home and community-based attendant services and supports, and only if the State meets the following requirements:

(A) AVAILABILITY.—The State shall make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing—

(i) under a person-centered plan of services and supports that is based on an assessment of functional need and that is agreed to in writing by the individual or, as appropriate, the individual's representative;

(ii) in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded;

(iii) under an agency-provider model or other model (as defined in paragraph (6)(C)); and

(iv) the furnishing of which—

(I) is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual's representative;

(II) is controlled, to the maximum extent possible, by the individual or where appropriate, the individual's representative, regardless of who may act as the employer of record; and

(III) provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary).

(B) INCLUDED SERVICES AND SUPPORTS.—In addition to assistance in accomplishing activities of daily living, instrumental activities of daily living, and health related tasks, the home and community-based attendant services and supports made available include—

(i) the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks;

(ii) back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports; and

(iii) voluntary training on how to select, manage, and dismiss attendants.

(C) EXCLUDED SERVICES AND SUPPORTS.—Subject to subparagraph (D), the home and community-based attendant services and supports made available do not include—

(i) room and board costs for the individual;

(ii) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

(iii) assistive technology devices and assistive technology services other than those under (1)(B)(ii);

(iv) medical supplies and equipment; or

(v) home modifications.

(D) PERMISSIBLE SERVICES AND SUPPORTS.—The home and community-based attendant services and supports may include—

(i) expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides; and

(ii) expenditures relating to a need identified in an individual's person-centered plan of services that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

(2) INCREASED FEDERAL FINANCIAL PARTICIPATION.—For purposes of payments to a State under section 1903(a)(1), with respect to amounts expended by the State to provide medical assistance under the State plan for home and community-based attendant services and supports to eligible individuals in accordance with this subsection during a fiscal year quarter occurring *on or after the date referred to in paragraph (1) and before January 1, 2020*, the Federal medical assistance percentage applicable to the State (as determined under section 1905(b)) shall be increased by 6 percentage points.

(3) STATE REQUIREMENTS.—In order for a State plan amendment to be approved under this subsection, the State shall—

(A) develop and implement such amendment in collaboration with a Development and Implementation Council established by the State that includes a majority of members with disabilities, elderly individuals, and their representatives and consults and collaborates with such individuals;

(B) provide consumer controlled home and community-based attendant services and supports to individuals on a

statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life;

(C) with respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, maintain or exceed the level of State expenditures for medical assistance that is provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year;

(D) establish and maintain a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports that—

(i) includes standards for agency-based and other delivery models with respect to training, appeals for denials and reconsideration procedures of an individual plan, and other factors as determined by the Secretary;

(ii) incorporates feedback from consumers and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community, and others and maximizes consumer independence and consumer control;

(iii) monitors the health and well-being of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports; and

(iv) provides information about the provisions of the quality assurance required under clauses (i) through (iii) to each individual receiving such services; and

(E) collect and report information, as determined necessary by the Secretary, for the purposes of approving the State plan amendment, providing Federal oversight, and conducting an evaluation under paragraph (5)(A), including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care.

(4) COMPLIANCE WITH CERTAIN LAWS.—A State shall ensure that, regardless of whether the State uses an agency-provider model or other models to provide home and community-based attendant services and supports under a State plan amendment under this subsection, such services and supports are

provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws regarding—

- (A) withholding and payment of Federal and State income and payroll taxes;
- (B) the provision of unemployment and workers compensation insurance;
- (C) maintenance of general liability insurance; and
- (D) occupational health and safety.

(5) EVALUATION, DATA COLLECTION, AND REPORT TO CONGRESS.—

(A) EVALUATION.—The Secretary shall conduct an evaluation of the provision of home and community-based attendant services and supports under this subsection in order to determine the effectiveness of the provision of such services and supports in allowing the individuals receiving such services and supports to lead an independent life to the maximum extent possible; the impact on the physical and emotional health of the individuals who receive such services; and an comparative analysis of the costs of services provided under the State plan amendment under this subsection and those provided under institutional care in a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded.

(B) DATA COLLECTION.—The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

- (i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this subsection during the fiscal year.
- (ii) The number of individuals that received such services and supports during the preceding fiscal year.
- (iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.
- (iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a waiver.

(C) REPORTS.—Not later than—

- (i) December 31, 2013, the Secretary shall submit to Congress and make available to the public an interim report on the findings of the evaluation under subparagraph (A); and
- (ii) December 31, 2015, the Secretary shall submit to Congress and make available to the public a final report on the findings of the evaluation under subparagraph (A).

(6) DEFINITIONS.—In this subsection:

(A) ACTIVITIES OF DAILY LIVING.—The term “activities of daily living” includes tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

(B) CONSUMER CONTROLLED.—The term “consumer controlled” means a method of selecting and providing services and supports that allow the individual, or where appropriate, the individual’s representative, maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record.

(C) DELIVERY MODELS.—

(i) AGENCY-PROVIDER MODEL.—The term “agency-provider model” means, with respect to the provision of home and community-based attendant services and supports for an individual, subject to paragraph (4), a method of providing consumer controlled services and supports under which entities contract for the provision of such services and supports.

(ii) OTHER MODELS.—The term “other models” means, subject to paragraph (4), methods, other than an agency-provider model, for the provision of consumer controlled services and supports. Such models may include the provision of vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.

(D) HEALTH-RELATED TASKS.—The term “health-related tasks” means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

(E) INDIVIDUAL’S REPRESENTATIVE.—The term “individual’s representative” means a parent, family member, guardian, advocate, or other authorized representative of an individual

(F) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term “instrumental activities of daily living” includes (but is not limited to) meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

* * * * *

LIENS, ADJUSTMENTS AND RECOVERIES, AND TRANSFERS OF ASSETS

SEC. 1917. (a)(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to—

(i) the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(ii) rights acquired by or assigned to the State in accordance with section 1902(a)(25)(H) or section 1912(a)(1)(A), or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b)(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B), the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of—

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan (but not including medical assistance for medicare cost-sharing or for benefits described in section 1902(a)(10)(E)).

(C)(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are dis-

regarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources—

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

(iii) For purposes of this paragraph, the term “qualified State long-term care insurance partnership” means an approved State plan amendment under this title that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the State plan amendment.

(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

(IV) If the policy is sold to an individual who—

(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

(V) The State Medicaid agency under section 1902(a)(5) provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount

of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time—

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligi-

ble to participate in such program) is blind or disabled as defined in section 1614; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B), when—

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),

is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(3)(A) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(B) The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility for Indian Tribes and Alaska Native Villages. Nothing in this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this title for Indians.

(4) For purposes of this subsection, the term "estate", with respect to a deceased individual—

(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(5)(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

(i) In the case of the model regulation, the following requirements:

(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

(III) Section 6C (relating to extension of benefits).

(IV) Section 6D (relating to continuation or conversion of coverage).

(V) Section 6E (relating to discontinuance and replacement of policies).

(VI) Section 7 (relating to unintentional lapse).

(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

(VIII) Section 9 (relating to required disclosure of rating practices to consumer).

(IX) Section 11 (relating to prohibitions against post-claims underwriting).

(X) Section 12 (relating to minimum standards).

(XI) Section 14 (relating to application forms and replacement coverage).

(XII) Section 15 (relating to reporting requirements).

(XIII) Section 22 (relating to filing requirements for marketing).

(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

(XV) Section 24 (relating to suitability).

(XVI) Section 25 (relating to prohibition against pre-existing conditions and probationary periods in replacement policies or certificates).

(XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

(XVIII) Section 29 (relating to standard format outline of coverage).

(XIX) Section 30 (relating to requirement to deliver shopper's guide).

(ii) In the case of the model Act, the following:

(I) Section 6C (relating to preexisting conditions).

(II) Section 6D (relating to prior hospitalization).

(III) The provisions of section 8 relating to contingent nonforfeiture benefits.

(IV) Section 6F (relating to right to return).

(V) Section 6G (relating to outline of coverage).

(VI) Section 6H (relating to requirements for certificates under group plans).

(VII) Section 6J (relating to policy summary).

(VIII) Section 6K (relating to monthly reports on accelerated death benefits).

(IX) Section 7 (relating to incontestability period).

(B) For purposes of this paragraph and paragraph (1)(C)—

(i) the terms “model regulation” and “model Act” mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);

(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and

(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.

(c)(1)(A) In order to meet the requirements of this subsection for purposes of section 1902(a)(18), the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(B)(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) or in the case of any other disposal of assets made on or after the date of the enactment of the Deficit Reduction Act of 2005, 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to—

(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

(C)(i) The services described in this subparagraph with respect to an institutionalized individual are the following:

(I) Nursing facility services.

(II) A level of care in any institution equivalent to that of nursing facility services.

(III) Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1915.

(ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), (22), or (24) of section 1905(a), and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.

(D)(i) In the case of a transfer of asset made before the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(ii) In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

(E)(i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(ii) With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced—

(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and

(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.

(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.

(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless—

(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this title; or

(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

(G) For purposes of this paragraph with respect to a transfer of assets, the term “assets” includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this title unless—

(i) the annuity is—

(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(II) purchased with proceeds from—

(aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such Code;

(bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or

(cc) a Roth IRA described in section 408A of such Code; or

(ii) the annuity—

(I) is irrevocable and nonassignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B), a State may determine the period of ineligibility applicable to such individual under this paragraph by—

(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.

(I) For purposes of this paragraph with respect to a transfer of assets, the term “assets” includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage—

(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual’s application for medical assistance for services described in subparagraph (C).

(J) For purposes of this paragraph with respect to a transfer of assets, the term “assets” includes the purchase of a life estate interest in another individual’s home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the assets transferred were a home and title to the home was transferred to—

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual’s home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual’s home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the assets—

(i) were transferred to the individual’s spouse or to another for the sole benefit of the individual’s spouse,

(ii) were transferred from the individual’s spouse to another for the sole benefit of the individual’s spouse,

(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4)) established solely for the

benefit of, the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1614(a)(3));

(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual; or

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary.

The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual. While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.

(3) For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(4) A State (including a State which has elected treatment under section 1902(f)) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.

(5) In this subsection, the term "resources" has the meaning given such term in section 1613, without regard to the exclusion described in subsection (a)(1) thereof.

(d)(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this title, subject

to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

- (i) The individual.
- (ii) The individual's spouse.
- (iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
- (iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(C) Subject to paragraph (4), this subsection shall apply without regard to—

- (i) the purposes for which a trust is established,
- (ii) whether the trustees have or exercise any discretion under the trust,
- (iii) any restrictions on when or whether distributions may be made from the trust, or
- (iv) any restrictions on the use of distributions from the trust.

(3)(A) In the case of a revocable trust—

- (i) the corpus of the trust shall be considered resources available to the individual,
- (ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and
- (iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c).

(B) In the case of an irrevocable trust—

- (i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—

(I) to or for the benefit of the individual, shall be considered income of the individual, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c); and

- (ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c), and the value of the trust shall be determined for purposes of such subsection

by including the amount of any payments made from such portion of the trust after such date.

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1614(a)(3)) and which is established for the benefit of such individual by the individual, a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this title.

(B) A trust established in a State for the benefit of an individual if—

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this title, and

(iii) the State makes medical assistance available to individuals described in section 1902(a)(10)(A)(ii)(V), but does not make such assistance available to individuals for nursing facility services under section 1902(a)(10)(C).

(C) A trust containing the assets of an individual who is disabled (as defined in section 1614(a)(3)) that meets the following conditions:

(i) The trust is established and managed by a nonprofit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1614(a)(3)) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this title.

(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

(6) The term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.

(e)(1) In order to meet the requirements of this section for purposes of section 1902(a)(18), a State shall require, as a condition for the provision of medical assistance for services described in sub-

section (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2)(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).

(f)(1)(A) Notwithstanding any other provision of this title, subject to [subparagraphs (B) and (C)] *subparagraph (B)* of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds \$500,000.

[(B) A State may elect, without regard to the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability), to apply subparagraph (A) by substituting for "\$500,000", an amount that exceeds such amount, but does not exceed \$750,000.]

[(C)] (B) The [dollar amounts specified in this paragraph] *dollar amount specified in subparagraph (A)* shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

(2) Paragraph (1) shall not apply with respect to an individual if—

(A) the spouse of such individual, or

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614,

is lawfully residing in the individual's home.

(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.

(g) TREATMENT OF ENTRANCE FEES OF INDIVIDUALS RESIDING IN CONTINUING CARE RETIREMENT COMMUNITIES.—

(1) IN GENERAL.—For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this title, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

(2) TREATMENT OF ENTRANCE FEE.—For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that—

(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

(h) In this section, the following definitions shall apply:

(1) The term "assets", with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action—

(A) by the individual or such individual's spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term "income" has the meaning given such term in section 1612.

(3) The term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom pay-

ment is made based on a level of care provided in a nursing facility, or who is described in section 1902(a)(10)(A)(ii)(VI).

(4) The term “noninstitutionalized individual” means an individual receiving any of the services specified in subsection (c)(1)(C)(ii).

(5) The term “resources” has the meaning given such term in section 1613, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

* * * * *

PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

SEC. 1920. (a) A State plan approved under section 1902 may provide for making ambulatory prenatal care available to a pregnant woman during a presumptive eligibility period.

(b) For purposes of this section—

(1) the term “presumptive eligibility period” means, with respect to a pregnant woman, the period that—

(A) begins with the date on which a qualified provider determines, on the basis of preliminary information, that the family income of the woman does not exceed the applicable income level of eligibility under the State plan, and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of the woman for medical assistance under the State plan, or

(ii) in the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination referred to in subparagraph (A), such last day; and

(2) the term “qualified provider” means any provider that—

(A) is eligible for payments under a State plan approved under this title,

(B) provides services of the type described in subparagraph (A) or (B) of section 1905(a)(2) or in section 1905(a)(9),

(C) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A), and

(D)(i) receives funds under—

(I) section 330 or 330A of the Public Health Service Act,

(II) title V of this Act, or

(III) title V of the Indian Health Care Improvement Act;

(ii) participates in a program established under—

(I) section 17 of the Child Nutrition Act of 1966, or

(II) section 4(a) of the Agriculture and Consumer Protection Act of 1973;

(iii) participates in a State perinatal program; or

(iv) is the Indian Health Service or is a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93–638). The term “qualified provider” also includes a qualified entity, as defined in section 1920A(b)(3).

(c)(1) The State agency shall provide qualified providers with—

(A) such forms as are necessary for a pregnant woman to make application for medical assistance under the State plan, and

(B) information on how to assist such women in completing and filing such forms.

(2) A qualified provider that determines under subsection (b)(1)(A) that a pregnant woman is presumptively eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

(B) inform the woman at the time the determination is made that she is required to make application for medical assistance under the State plan by not later than the last day of the month following the month during which the determination is made.

(3) A pregnant woman who is determined by a qualified provider to be presumptively eligible for medical assistance under a State plan shall make application for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1902(l)(1)(A).

(d) Notwithstanding any other provision of this title, ambulatory prenatal care that—

(1) is furnished to a pregnant woman—

(A) during a presumptive eligibility period,

(B) by a provider that is eligible for payments under the State plan; and

(2) is included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1903.

(e) If the State has elected the option to provide a presumptive eligibility period under this section or section 1920A, the State may elect to provide a presumptive eligibility period (as defined in subsection (b)(1)) for individuals who are eligible for medical assistance **under clause (i)(VIII), clause (i)(IX), or clause (ii)(XX) of subsection (a)(10)(A)] under clause (i)(VIII) or clause (ii)(XX) of section 1902(a)(10)(A) before January 1, 2020, section 1902(a)(10)(A)(i)(IX), or section 1931 in the same manner as the State provides for such a period under this section or section 1920A, subject to such guidance as the Secretary shall establish.**

* * * * *

ADJUSTMENT IN PAYMENT FOR INPATIENT HOSPITAL SERVICES
FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS

SEC. 1923. (a) IMPLEMENTATION OF REQUIREMENT.—

(1) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(13)(A)(iv) (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that—

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) which meets the requirements of subsection (d)), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c).

(2)(A) In order to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, the State plan amendment described in paragraph (1), consistent with subsection (c), effective for inpatient hospital services provided on or after July 1, 1989.

(B) In order to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1990, the State must submit to the Secretary by not later than April 1, 1990, the State plan amendment described in paragraph (1), consistent with subsections (c) and (f), effective for inpatient hospital services provided on or after July 1, 1990.

(C) If a State plan under this title provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

(D) A State plan under this title shall not be considered to meet the requirements of section 1902(a)(13)(A)(iv) (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, unless the State has submitted to the Secretary by such date a description of the methodology used by the State to identify and to make payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients (including such patients who receive benefits through a managed care entity) served by such

hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to each such disproportionate share hospital.

(3) The Secretary shall, not later than 90 days after the date a State submits an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) The requirement of this subsection may not be waived under section 1915(b)(4).

(b) HOSPITALS DEEMED DISPROPORTIONATE SHARE.—

(1) For purposes of subsection (a)(1), a hospital which meets the requirements of subsection (d) is deemed to be a disproportionate share hospital if—

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term “medicaid inpatient utilization rate” means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this title in a period (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term “inpatient day” includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(3) For purposes of paragraph (1)(B), the term “low-income utilization rate” means, for a hospital, the sum of—

(A) the fraction (expressed as a percentage)—

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this title (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(B) a fraction (expressed as a percentage)—

(i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which

are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under this title).

(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1903(w)(1)(A)(iii) if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1903(w)(4).

(c) PAYMENT ADJUSTMENT.—Subject to subsections (f) and (g), in order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either—

(1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1886(a)(4)), and (B) the hospital's disproportionate share adjustment percentage (established under section 1886(d)(5)(F)(iv));

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and (without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1)) for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2)) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in paragraph (b)(3)); or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that—

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this title or to low-income patients,

except that, for purposes of paragraphs (1)(B) and (2)(A) of subsection (a), the payment adjustment for a disproportionate share hospital is consistent with this subsection if the appropriate increase in the rate or amount of payment is equal to at least one-third of the increase otherwise applicable under this subsection (in the case of such paragraph (1)(B)) and at least two-thirds of such increase (in the case of such paragraph (2)(A)). In the case of a hospital described in subsection

(d)(2)(A)(i) (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1886(d)(5)(F)(vi)) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.

(d) REQUIREMENTS TO QUALIFY AS DISPROPORTIONATE SHARE HOSPITAL.—

(1) Except as provided in paragraph (2), no hospital may be defined or deemed as a disproportionate share hospital under a State plan under this title or under subsection (b) of this section unless the hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2)(A) Paragraph (1) shall not apply to a hospital—

- (i) the inpatients of which are predominantly individuals under 18 years of age; or
- (ii) which does not offer nonemergency obstetric services to the general population as of the date of the enactment of this Act.

(B) In the case of a hospital located in a rural area (as defined for purposes of section 1886), in paragraph (1) the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(3) No hospital may be defined or deemed as a disproportionate share hospital under a State plan under this title or under subsection (b) or (e) of this section unless the hospital has a medicaid inpatient utilization rate (as defined in subsection (b)(2)) of not less than 1 percent.

(e) SPECIAL RULE.—(1) A State plan shall be considered to meet the requirement of section 1902(a)(13)(A)(iv) (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs) without regard to the requirement of subsection (a) if (A)(i) the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984, or (ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital, (B) the aggregate amount of the payment adjustments under the plan for such hos-

pitals is not less than the aggregate amount of such adjustments otherwise required to be made under such subsection, and (C) the plan meets the requirement of subsection (d)(3) and such payment adjustments are made consistent with the last sentence of subsection (c).

(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a state-wide basis, beginning on July 1, 1988—

(A) the requirements of subsections (b) and (c) (other than the last sentence of subsection (c)) shall not apply if the aggregate amount of the payment adjustments under the plan for disproportionate share hospitals (as defined under the State plan) is not less than the aggregate amount of payment adjustments otherwise required to be made if such subsections applied,

(B) subsection (d)(2)(B) shall apply to hospitals located in urban areas, as well as in rural areas,

(C) subsection (d)(3) shall apply, and

(D) subsection (g) shall apply.

(f) **LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—**

(1) **IN GENERAL.**—Payment under section 1903(a) shall not be made to a State with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year in excess of the disproportionate share hospital (in this subsection referred to as “DSH”) allotment for the State for the fiscal year, as specified in paragraphs (2), (3), and (7).

(2) **STATE DSH ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2002.**—Subject to paragraph (4), the DSH allotment for a State for each fiscal year during the period beginning with fiscal year 1998 and ending with fiscal year 2002 is determined in accordance with the following table:

State or District	DSH Allotment (in millions of dollars)				
	FY 98	FY 99	FY 00	FY 01	FY 02
Alabama	293	269	248	246	246
Alaska	10	10	10	9	9
Arizona	81	81	81	81	81
Arkansas	2	2	2	2	2
California	1,085	1,068	986	931	877
Colorado	93	85	79	74	74
Connecticut	200	194	164	160	160
Delaware	4	4	4	4	4
District of Columbia	23	23	49	49	49
Florida	207	203	197	188	160
Georgia	253	248	241	228	215
Hawaii	0	0	0	0	0
Idaho	1	1	1	1	1
Illinois	203	199	193	182	172
Indiana	201	197	191	181	171
Iowa	8	8	8	8	8
Kansas	51	49	42	36	33
Kentucky	137	134	130	123	116
Louisiana	880	795	713	658	631
Maine	103	99	84	84	84
Maryland	72	70	68	64	61
Massachusetts	288	282	273	259	244
Michigan	249	244	237	224	212
Minnesota	16	¹ 16	33	33	33
Mississippi	143	141	136	129	122
Missouri	436	423	379	379	379

State or District	DSH Allotment (in millions of dollars)				
	FY 98	FY 99	FY 00	FY 01	FY 02
Montana	0.2	0.2	0.2	0.2	0.2
Nebraska	5	5	5	5	5
Nevada	37	37	37	37	37
New Hampshire	140	136	130	130	130
New Jersey	600	582	515	515	515
New Mexico	5	² 5	9	9	9
New York	1,512	1,482	1,436	1,361	1,285
North Carolina	278	272	264	250	236
North Dakota	1	1	1	1	1
Ohio	382	374	363	344	325
Oklahoma	16	16	16	16	16
Oregon	20	20	20	20	20
Pennsylvania	529	518	502	476	449
Rhode Island	62	60	58	55	52
South Carolina	313	303	262	262	262
South Dakota	1	1	1	1	1
Tennessee	0	0	0	0	0
Texas	979	950	806	765	765
Utah	3	3	3	3	3
Vermont	18	18	18	18	18
Virginia	70	68	66	63	59
Washington	174	171	166	157	148
West Virginia	64	63	61	58	54
Wisconsin	7	7	7	7	7
Wyoming	0	³ 0	0.1	0.1	0.1

¹The DSH allotment for fiscal year 1999 shall be deemed to be \$33,000,000 as provided for by section 702 of Public Law 105–277 (112 Stat. 2681–389).

²The DSH allotment for fiscal year 1999 shall be deemed to be \$9,000,000 as provided for by section 703 of Public Law 105–277 (112 Stat. 2681–389).

³The DSH allotment for fiscal year 1999 shall be deemed to be \$95,000 as provided for by section 704 of Public Law 105–277 (112 Stat. 2681–389).

(3) STATE DSH ALLOTMENTS FOR FISCAL YEAR 2003 AND THEREAFTER.—

(A) IN GENERAL.—Except as provided in paragraphs (6), (7), and (8) and subparagraph (E), the DSH allotment for any State for fiscal year 2003 and each succeeding fiscal year is equal to the DSH allotment for the State for the preceding fiscal year under paragraph (2) or this paragraph, increased, subject to subparagraphs (B) and (C) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

(B) LIMITATION.—The DSH allotment for a State shall not be increased under subparagraph (A) for a fiscal year to the extent that such an increase would result in the DSH allotment for the year exceeding the greater of—

- (i) the DSH allotment for the previous year, or
- (ii) 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year.

(C) SPECIAL, TEMPORARY INCREASE IN ALLOTMENTS ON A ONE-TIME, NON-CUMULATIVE BASIS.—The DSH allotment for any State (other than a State with a DSH allotment determined under paragraph (5))—

- (i) for fiscal year 2004 is equal to 116 percent of the DSH allotment for the State for fiscal year 2003 under this paragraph, notwithstanding subparagraph (B); and

(ii) for each succeeding fiscal year is equal to the DSH allotment for the State for fiscal year 2004 or, in the case of fiscal years beginning with the fiscal year specified in subparagraph (D) for that State, the DSH allotment for the State for the previous fiscal year increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

(D) FISCAL YEAR SPECIFIED.—For purposes of subparagraph (C)(ii), the fiscal year specified in this subparagraph for a State is the first fiscal year for which the Secretary estimates that the DSH allotment for that State will equal (or no longer exceed) the DSH allotment for that State under the law as in effect before the date of the enactment of this subparagraph.

(E) TEMPORARY INCREASE IN ALLOTMENTS DURING RECESSION.—

(i) IN GENERAL.—Subject to clause (ii), the DSH allotment for any State—

(I) for fiscal year 2009 is equal to 102.5 percent of the DSH allotment that would be determined under this paragraph for the State for fiscal year 2009 without application of this subparagraph, notwithstanding subparagraphs (B) and (C);

(II) for fiscal year 2010 is equal to 102.5 percent of the DSH allotment for the State for fiscal year 2009, as determined under subclause (I); and

(III) for each succeeding fiscal year is equal to the DSH allotment for the State under this paragraph determined without applying subclauses (I) and (II).

(ii) APPLICATION.—Clause (i) shall not apply to a State for a year in the case that the DSH allotment for such State for such year under this paragraph determined without applying clause (i) would grow higher than the DSH allotment specified under clause (i) for the State for such year.

(4) SPECIAL RULE FOR FISCAL YEARS 2001 AND 2002.—

(A) IN GENERAL.—Notwithstanding paragraph (2), the DSH allotment for any State for—

(i) fiscal year 2001, shall be the DSH allotment determined under paragraph (2) for fiscal year 2000 increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2000; and

(ii) fiscal year 2002, shall be the DSH allotment determined under clause (i) increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2001.

(B) LIMITATION.—Subparagraph (B) of paragraph (3) shall apply to subparagraph (A) of this paragraph in the

same manner as that subparagraph (B) applies to paragraph (3)(A).

(C) NO APPLICATION TO ALLOTMENTS AFTER FISCAL YEAR 2002.—The DSH allotment for any State for fiscal year 2003 or any succeeding fiscal year shall be determined under paragraph (3) without regard to the DSH allotments determined under subparagraph (A) of this paragraph.

(5) SPECIAL RULE FOR LOW DSH STATES.—

(A) FOR FISCAL YEARS 2001 THROUGH 2003 FOR EXTREMELY LOW DSH STATES.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 1999, as reported to the Administrator of the Health Care Financing Administration as of August 31, 2000, is greater than 0 but less than 1 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2001 shall be increased to 1 percent of the State's total amount of expenditures under such plan for such assistance during such fiscal year. In subsequent fiscal years before fiscal year 2004, such increased allotment is subject to an increase for inflation as provided in paragraph (3)(A).

(B) FOR FISCAL YEAR 2004 AND SUBSEQUENT FISCAL YEARS.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for the State with respect to—

- (i) fiscal year 2004 shall be the DSH allotment for the State for fiscal year 2003 increased by 16 percent;
- (ii) each succeeding fiscal year before fiscal year 2009 shall be the DSH allotment for the State for the previous fiscal year increased by 16 percent; and
- (iii) fiscal year 2009 and any subsequent fiscal year, shall be the DSH allotment for the State for the previous year subject to an increase for inflation as provided in paragraph (3)(A).

(6) ALLOTMENT ADJUSTMENTS.—

(A) TENNESSEE.—

(i) IN GENERAL.—Only with respect to fiscal year 2007, the DSH allotment for Tennessee for such fiscal year, notwithstanding the table set forth in paragraph (2) or the terms of the TennCare Demonstration Project in effect for the State, shall be the greater of—

(I) the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for the demonstration year ending in 2006 that is reflected in

the budget neutrality provision of the TennCare Demonstration Project; and

(II) \$280,000,000.

Only with respect to fiscal years 2008, 2009, 2010, and 2011, the DSH allotment for Tennessee for the fiscal year, notwithstanding such table or terms, shall be the amount specified in the previous sentence for fiscal year 2007. Only with respect to fiscal year 2012 for the period ending on December 31, 2011, the DSH allotment for Tennessee for such portion of the fiscal year, notwithstanding such table or terms, shall be $\frac{1}{4}$ of the amount specified in the first sentence for fiscal year 2007.

(ii) LIMITATION ON AMOUNT OF PAYMENT ADJUSTMENTS ELIGIBLE FOR FEDERAL FINANCIAL PARTICIPATION.—Payment under section 1903(a) shall not be made to Tennessee with respect to the aggregate amount of any payment adjustments made under this section for hospitals in the State for fiscal year 2007, 2008, 2009, 2010, 2011, or for period in fiscal year 2012 described in clause (i) that is in excess of 30 percent of the DSH allotment for the State for such fiscal year or period determined pursuant to clause (i).

(iii) STATE PLAN AMENDMENT.—The Secretary shall permit Tennessee to submit an amendment to its State plan under this title that describes the methodology to be used by the State to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities. The Secretary may not approve such plan amendment unless the methodology described in the amendment is consistent with the requirements under this section for making payment adjustments to disproportionate share hospitals. For purposes of demonstrating budget neutrality under the TennCare Demonstration Project, payment adjustments made pursuant to a State plan amendment approved in accordance with this subparagraph shall be considered expenditures under such project.

(iv) OFFSET OF FEDERAL SHARE OF PAYMENT ADJUSTMENTS FOR FISCAL YEARS 2007 THROUGH 2011 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2012 AGAINST ESSENTIAL ACCESS HOSPITAL SUPPLEMENTAL POOL PAYMENTS UNDER THE TENNCARE DEMONSTRATION PROJECT.—

(I) The total amount of Essential Access Hospital supplemental pool payments that may be made under the TennCare Demonstration Project for fiscal year 2007, 2008, 2009, 2010, 2011, or for a period in fiscal year 2012 described in clause (i) shall be reduced on a dollar for dollar basis by the amount of any payments made under section 1903(a) to Tennessee with respect to payment ad-

justments made under this section for hospitals in the State for such fiscal year or period.

(II) The sum of the total amount of payments made under section 1903(a) to Tennessee with respect to payment adjustments made under this section for hospitals in the State for fiscal year 2007, 2008, 2009, 2010, 2011, or for a period in fiscal year 2012 described in clause (i) and the total amount of Essential Access Hospital supplemental pool payments made under the TennCare Demonstration Project for such fiscal year or period shall not exceed the State's DSH allotment for such fiscal or period year established under clause (i).

(v) ALLOTMENT FOR 2D, 3RD, AND 4TH QUARTERS OF FISCAL YEAR 2012 AND FOR FISCAL YEAR 2013.—Notwithstanding the table set forth in paragraph (2):

(I) 2D, 3RD, AND 4TH QUARTERS OF FISCAL YEAR 2012.—In the case of a State that has a DSH allotment of \$0 for the 2d, 3rd, and 4th quarters of fiscal year 2012, the DSH allotment shall be \$47,200,000 for such quarters.

(II) FISCAL YEAR 2013.—In the case of a State that has a DSH allotment of \$0 for fiscal year 2013, the DSH allotment shall be \$53,100,000 for such fiscal year.

(vi) ALLOTMENT FOR FISCAL YEARS 2015 THROUGH 2025.—Notwithstanding any other provision of this subsection, any other provision of law, or the terms of the TennCare Demonstration Project in effect for the State, the DSH allotment for Tennessee for fiscal year 2015, and for each fiscal year thereafter through fiscal year 2025, shall be \$53,100,000 for each such fiscal year.

(B) HAWAII.—

(i) IN GENERAL.—Only with respect to each of fiscal years 2007 through 2011, the DSH allotment for Hawaii for such fiscal year, notwithstanding the table set forth in paragraph (2), shall be \$10,000,000. Only with respect to fiscal year 2012 for the period ending on December 31, 2011, the DSH allotment for Hawaii for such portion of the fiscal year, notwithstanding the table set forth in paragraph (2), shall be \$2,500,000.

(ii) STATE PLAN AMENDMENT.—The Secretary shall permit Hawaii to submit an amendment to its State plan under this title that describes the methodology to be used by the State to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities. The Secretary may not approve such plan amendment unless the methodology described in the amendment is consistent with the requirements under this section for making payment adjustments to disproportionate share hospitals.

(iii) ALLOTMENT FOR 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012, FISCAL YEAR 2013, AND SUCCEEDING FISCAL YEARS.—Notwithstanding the table set forth in paragraph (2):

(I) 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012.—The DSH allotment for Hawaii for the 2d, 3rd, and 4th quarters of fiscal year 2012 shall be \$7,500,000.

(II) TREATMENT AS A LOW-DSH STATE FOR FISCAL YEAR 2013 AND SUCCEEDING FISCAL YEARS.—With respect to fiscal year 2013, and each fiscal year thereafter, the DSH allotment for Hawaii shall be increased in the same manner as allotments for low DSH States are increased for such fiscal year under clause (iii) of paragraph (5)(B).

(III) CERTAIN HOSPITAL PAYMENTS.—The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to the extent that such limitation is necessary to ensure that a hospital does not receive payments in excess of the amounts described in subsection (g), or as necessary to ensure that such payments under the waiver and such payments pursuant to the allotment provided in this clause do not, in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project.

(7) MEDICAID DSH REDUCTIONS.—

(A) REDUCTIONS.—

(i) IN GENERAL.—For each of fiscal years 2018 through **2025** 2019 the Secretary shall effect the following reductions:

(I) REDUCTION IN DSH ALLOTMENTS.—The Secretary shall reduce DSH allotments to States in the amount specified under the DSH health reform methodology under subparagraph (B) for the State for the fiscal year.

(II) REDUCTIONS IN PAYMENTS.—The Secretary shall reduce payments to States under section 1903(a) for each calendar quarter in the fiscal year, in the manner specified in clause (iii), in an amount equal to $\frac{1}{4}$ of the DSH allotment reduction under subclause (I) for the State for the fiscal year.

(ii) AGGREGATE REDUCTIONS.—The aggregate reductions in DSH allotments for all States under clause (i)(I) shall be equal to—

(I) \$2,000,000,000 for fiscal year 2018; and

(II) \$3,000,000,000 for fiscal year 2019**;**.

- [(III) \$4,000,000,000 for fiscal year 2020;
- [(IV) \$5,000,000,000 for fiscal year 2021;
- [(V) \$6,000,000,000 for fiscal year 2022;
- [(VI) \$7,000,000,000 for fiscal year 2023;
- [(VII) \$8,000,000,000 for fiscal year 2024; and
- [(VIII) \$8,000,000,000 for fiscal year 2025.]]

(iii) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under clause (i)(II) for a State for a quarter shall be deemed an overpayment to the State under this title to be disallowed against the State's regular quarterly draw for all spending under section 1903(d)(2). Such a disallowance is not subject to a reconsideration under subsections (d) and (e) of section 1116.

(iv) DEFINITION.—In this paragraph, the term “State” means the 50 States and the District of Columbia.

(v) DISTRIBUTION OF AGGREGATE REDUCTIONS.—The Secretary shall distribute the aggregate reductions under clause (ii) among States in accordance with subparagraph (B).

(B) DSH HEALTH REFORM METHODOLOGY.—The Secretary shall carry out subparagraph (A) through use of a DSH Health Reform methodology that meets the following requirements:

(i) The methodology imposes the largest percentage reductions on the States that—

(I) have the lowest percentages of uninsured individuals (determined on the basis of data from the Bureau of the Census, audited hospital cost reports, and other information likely to yield accurate data) during the most recent year for which such data are available; or

(II) do not target their DSH payments on—

(aa) hospitals with high volumes of Medicaid inpatients (as defined in subsection (b)(1)(A)); and

(bb) hospitals that have high levels of uncompensated care (excluding bad debt).

(ii) The methodology imposes a smaller percentage reduction on low DSH States described in paragraph (5)(B).

(iii) The methodology takes into account the extent to which the DSH allotment for a State was included in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009.

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

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

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

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

(I) *The term “expansion State” means with respect to a fiscal year, a State that, as of July 1 of the preceding fiscal year, provides for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) for medical assistance under this title (or a waiver of the State plan approved under section 1115).*

(II) *The term “non-expansion State” means, with respect to a fiscal year, a State that is not an expansion State.*

(8) *CALCULATION OF DSH ALLOTMENTS AFTER REDUCTIONS PERIOD.*—The DSH allotment for a State for fiscal years after **[fiscal year 2025]** *fiscal year 2019* shall be calculated under paragraph (3) without regard to paragraph (7).

(9) *DEFINITION OF STATE.*—In this subsection, the term “State” means the 50 States and the District of Columbia.

(g) *LIMIT ON AMOUNT OF PAYMENT TO HOSPITAL.*—

(1) *AMOUNT OF ADJUSTMENT SUBJECT TO UNCOMPENSATED COSTS.*—

(A) *IN GENERAL.*—A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) with respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year. For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment.

(B) *LIMIT TO PUBLIC HOSPITALS DURING TRANSITION PERIOD.*—With respect to payment adjustments during a State fiscal year that begins before January 1, 1995, subparagraph (A) shall apply only to hospitals owned or operated by a State (or by an instrumentality or a unit of government within a State).

(C) *MODIFICATIONS FOR PRIVATE HOSPITALS.*—With respect to hospitals that are not owned or operated by a State (or by an instrumentality or a unit of government within a State), the Secretary may make such modifications to the manner in which the limitation on payment adjustments is applied to such hospitals as the Secretary considers appropriate.

(2) ADDITIONAL AMOUNT DURING TRANSITION PERIOD FOR CERTAIN HOSPITALS WITH HIGH DISPROPORTIONATE SHARE.—

(A) IN GENERAL.—In the case of a hospital with high disproportionate share (as defined in subparagraph (B)), a payment adjustment during a State fiscal year that begins before January 1, 1995, shall be considered consistent with subsection (c) if the payment adjustment does not exceed 200 percent of the costs of furnishing hospital services described in paragraph (1)(A) during the year, but only if the Governor of the State certifies to the satisfaction of the Secretary that the hospital's applicable minimum amount is used for health services during the year. In determining the amount that is used for such services during a year, there shall be excluded any amounts received under the Public Health Service Act, title V, title XVIII, or from third party payors (not including the State plan under this title) that are used for providing such services during the year.

(B) HOSPITALS WITH HIGH DISPROPORTIONATE SHARE DEFINED.—In subparagraph (A), a hospital is a “hospital with high disproportionate share” if—

(i) the hospital is owned or operated by a State (or by an instrumentality or a unit of government within a State); and

(ii) the hospital—

(I) meets the requirement described in subsection (b)(1)(A), or

(II) has the largest number of inpatient days attributable to individuals entitled to benefits under the State plan of any hospital in such State for the previous State fiscal year.

(C) APPLICABLE MINIMUM AMOUNT DEFINED.—In subparagraph (A), the “applicable minimum amount” for a hospital for a fiscal year is equal to the difference between the amount of the hospital's payment adjustment for the fiscal year and the costs to the hospital of furnishing hospital services described in paragraph (1)(A) during the fiscal year.

(h) LIMITATION ON CERTAIN STATE DSH EXPENDITURES.—

(1) IN GENERAL.—Payment under section 1903(a) shall not be made to a State with respect to any payment adjustments made under this section for quarters in a fiscal year (beginning with fiscal year 1998) to institutions for mental diseases or other mental health facilities, to the extent the aggregate of such adjustments in the fiscal year exceeds the lesser of the following:

(A) 1995 IMD DSH PAYMENT ADJUSTMENTS.—The total State DSH expenditures that are attributable to fiscal year 1995 for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(B) APPLICABLE PERCENTAGE OF 1995 TOTAL DSH PAYMENT ALLOTMENT.—The amount of such payment adjustments which are equal to the applicable percentage of the Federal

share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for the State for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(2) APPLICABLE PERCENTAGE.—

(A) IN GENERAL.—For purposes of paragraph (1), the applicable percentage with respect to—

- (i) each of fiscal years 1998, 1999, and 2000, is the percentage determined under subparagraph (B); or
- (ii) a succeeding fiscal year is the lesser of the percentage determined under subparagraph (B) or the following percentage:

(I) For fiscal year 2001, 50 percent.

(II) For fiscal year 2002, 40 percent.

(III) For each succeeding fiscal year, 33 percent.

(B) 1995 PERCENTAGE.—The percentage determined under this subparagraph is the ratio (determined as a percentage) of—

- (i) the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary) for payments to institutions for mental diseases and other mental health facilities, to
- (ii) the State 1995 DSH spending amount.

(C) STATE 1995 DSH SPENDING AMOUNT.—For purposes of subparagraph (B)(ii), the “State 1995 DSH spending amount”, with respect to a State, is the Federal medical assistance percentage (for fiscal year 1995) of the payment adjustments made under subsection (c) under the State plan that are attributable to the fiscal year 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary).

(i) REQUIREMENT FOR DIRECT PAYMENT.—

(1) IN GENERAL.—No payment may be made under section 1903(a)(1) with respect to a payment adjustment made under this section, for services furnished by a hospital on or after October 1, 1997, with respect to individuals eligible for medical assistance under the State plan who are enrolled with a managed care entity (as defined in section 1932(a)(1)(B)) or under any other managed care arrangement unless a payment, equal to the amount of the payment adjustment—

(A) is made directly to the hospital by the State; and

(B) is not used to determine the amount of a prepaid capitation payment under the State plan to the entity or arrangement with respect to such individuals.

(2) EXCEPTION FOR CURRENT ARRANGEMENTS.—Paragraph (1) shall not apply to a payment adjustment provided pursuant to a payment arrangement in effect on July 1, 1997.

(j) ANNUAL REPORTS AND OTHER REQUIREMENTS REGARDING PAYMENT ADJUSTMENTS.—With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1903(a)(1) with respect to a payment adjustment made under this section, to do the following:

(1) REPORT.—The State shall submit an annual report that includes the following:

(A) An identification of each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year.

(B) Such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.

(2) INDEPENDENT CERTIFIED AUDIT.—The State shall annually submit to the Secretary an independent certified audit that verifies each of the following:

(A) The extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under this section.

(B) Payments under this section to hospitals that comply with the requirements of subsection (g).

(C) Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph (1)(A) of such subsection are included in the calculation of the hospital-specific limits under such subsection.

(D) The State included all payments under this title, including supplemental payments, in the calculation of such hospital-specific limits.

(E) The State has separately documented and retained a record of all of its costs under this title, claimed expenditures under this title, uninsured costs in determining payment adjustments under this section, and any payments made on behalf of the uninsured from payment adjustments under this section.

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

SEC. 1923A. (a) *IN GENERAL.*—Subject to the limitations of this section, for each year during the period beginning with 2018 and ending with 2021, each State that is one of the 50 States or the District of Columbia and that, as of July 1 of the preceding year, did not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) for medical assistance under this title (or a waiver of the State plan approved under section 1115) (each such State or District referred to in this section for the year as a “non-expansion State”) may adjust the payment amounts otherwise provided under the State plan under this title (or a waiver of such plan) to health care providers that provide health care services to individuals en-

rolled under this title (in this section referred to as “eligible providers”).

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

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

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

(c) *LIMITATIONS; DISQUALIFICATION OF STATES.*—

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

(A) the population of the State with income below 138 percent of the poverty line in 2015 (as determined based the table entitled “Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age” for the universe of the civilian noninstitutionalized population for whom poverty status is determined based on the 2015 American Community Survey 1-Year Estimates, as published by the Bureau of the Census), to

(B) the sum of the populations under subparagraph (A) for all non-expansion States.

(2) *LIMITATION ON PAYMENT ADJUSTMENT AMOUNT FOR INDIVIDUAL PROVIDERS.*—The amount of a payment adjustment under subsection (a) for an eligible provider may not exceed the provider's costs incurred in furnishing health care services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) to individuals who either are eligible for medical assistance under the State plan (or under a waiver of such plan) or have no health insurance or health plan coverage for such services.

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

* * * * *

STATE FLEXIBILITY IN BENEFIT PACKAGES

SEC. 1937. (a) STATE OPTION OF PROVIDING BENCHMARK BENEFITS.—

(1) AUTHORITY.—

(A) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability) and any other provision of this title which would be directly contrary to the authority under this section and subject to subsection (E), a State, at its option as a State plan amendment, may provide for medical assistance under this title to individuals within one or more groups of individuals specified by the State through coverage that—

(i) provides benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); and

(ii) for any individual described in section 1905(a)(4)(B) who is eligible under the State plan in accordance with paragraphs (10) and (17) of section 1902(a), consists of the items and services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with the requirements of section 1902(a)(43).

(B) LIMITATION.—The State may only exercise the option under subparagraph (A) for an individual eligible under subclause (VIII) of section 1902(a)(10)(A)(i) or under an eligibility category that had been established under the State plan on or before the date of the enactment of this section.

(C) OPTION OF ADDITIONAL BENEFITS.—In the case of coverage described in subparagraph (A), a State, at its option, may provide such additional benefits as the State may specify.

(D) TREATMENT AS MEDICAL ASSISTANCE.—Payment of premiums for such coverage under this subsection shall be treated as payment of other insurance premiums described in the third sentence of section 1905(a).

(E) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as—

(i) requiring a State to offer all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2);

(ii) preventing a State from offering all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); or

(iii) affecting a child's entitlement to care and services described in subsections (a)(4)(B) and (r) of section 1905 and provided in accordance with section 1902(a)(43) whether provided through benchmark coverage, benchmark equivalent coverage, or otherwise.

(2) APPLICATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a State may require that a full-benefit eligible individual (as defined in subparagraph (C)) within a group obtain benefits under this title through enrollment in coverage described in paragraph (1)(A). A State may apply the previous sentence to individuals within 1 or more groups of such individuals.

(B) LIMITATION ON APPLICATION.—A State may not require under subparagraph (A) an individual to obtain benefits through enrollment described in paragraph (1)(A) if the individual is within one of the following categories of individuals:

(i) MANDATORY PREGNANT WOMEN.—The individual is a pregnant woman who is required to be covered under the State plan under section 1902(a)(10)(A)(i).

(ii) BLIND OR DISABLED INDIVIDUALS.—The individual qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

(iii) DUAL ELIGIBLES.—The individual is entitled to benefits under any part of title XVIII.

(iv) TERMINALLY ILL HOSPICE PATIENTS.—The individual is terminally ill and is receiving benefits for hospice care under this title.

(v) ELIGIBLE ON BASIS OF INSTITUTIONALIZATION.—The individual is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical

care all but a minimal amount of the individual's income required for personal needs.

(vi) **MEDICALLY FRAIL AND SPECIAL MEDICAL NEEDS INDIVIDUALS.**—The individual is medically frail or otherwise an individual with special medical needs (as identified in accordance with regulations of the Secretary).

(vii) **BENEFICIARIES QUALIFYING FOR LONG-TERM CARE SERVICES.**—The individual qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C).

(viii) **CHILDREN IN FOSTER CARE RECEIVING CHILD WELFARE SERVICES AND CHILDREN RECEIVING FOSTER CARE OR ADOPTION ASSISTANCE.**—The individual is an individual with respect to whom child welfare services are made available under part B of title IV on the basis of being a child in foster care or with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age, or the individual qualifies for medical assistance on the basis of section 1902(a)(10)(A)(i)(IX).

(ix) **TANF AND SECTION 1931 PARENTS.**—The individual qualifies for medical assistance on the basis of eligibility to receive assistance under a State plan funded under part A of title IV (as in effect on or after the welfare reform effective date defined in section 1931(i)).

(x) **WOMEN IN THE BREAST OR CERVICAL CANCER PROGRAM.**—The individual is a woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

(xi) **LIMITED SERVICES BENEFICIARIES.**—The individual—

(I) qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII); or

(II) is not a qualified alien (as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) and receives care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v).

(C) **FULL-BENEFIT ELIGIBLE INDIVIDUALS.**—

(i) **IN GENERAL.**—For purposes of this paragraph, subject to clause (ii), the term “full-benefit eligible individual” means for a State for a month an individual who is determined eligible by the State for medical assistance for all services defined in section 1905(a) which are covered under the State plan under this title for such month under section 1902(a)(10)(A) or under any other category of eligibility for medical assistance for all such services under this title, as determined by the Secretary.

(ii) **EXCLUSION OF MEDICALLY NEEDY AND SPEND-DOWN POPULATIONS.**—Such term shall not include an

individual determined to be eligible by the State for medical assistance under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care.

(b) BENCHMARK BENEFIT PACKAGES.—

(1) IN GENERAL.—For purposes of subsection (a)(1), subject to paragraphs (5) and (6), each of the following coverages shall be considered to be benchmark coverage:

(A) FEHBP-EQUIVALENT HEALTH INSURANCE COVERAGE.—The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

(B) STATE EMPLOYEE COVERAGE.—A health benefits coverage plan that is offered and generally available to State employees in the State involved.

(C) COVERAGE OFFERED THROUGH HMO.—The health insurance coverage plan that—

(i) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act), and

(ii) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

(D) SECRETARY-APPROVED COVERAGE.—Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage.

(2) BENCHMARK-EQUIVALENT COVERAGE.—For purposes of subsection (a)(1), subject to paragraphs (5) and (6) coverage that meets the following requirement shall be considered to be benchmark-equivalent coverage:

(A) INCLUSION OF BASIC SERVICES.—The coverage includes benefits for items and services within each of the following categories of basic services:

(i) Inpatient and outpatient hospital services.

(ii) Physicians' surgical and medical services.

(iii) Laboratory and x-ray services.

(iv) Coverage of prescription drugs.

(v) Mental health services.

(vi) Well-baby and well-child care, including age-appropriate immunizations.

(vii) Other appropriate preventive services, as designated by the Secretary.

(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE.—The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages described in paragraph (1).

(C) SUBSTANTIAL ACTUARIAL VALUE FOR ADDITIONAL SERVICES INCLUDED IN BENCHMARK PACKAGE.—With respect to each of the following categories of additional services for which coverage is provided under the benchmark

benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package:

- (i) Vision services.
- (ii) Hearing services.

(3) DETERMINATION OF ACTUARIAL VALUE.—The actuarial value of coverage of benchmark benefit packages shall be set forth in an actuarial opinion in an actuarial report that has been prepared—

(A) by an individual who is a member of the American Academy of Actuaries;

(B) using generally accepted actuarial principles and methodologies;

(C) using a standardized set of utilization and price factors;

(D) using a standardized population that is representative of the population involved;

(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under this title that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

(4) COVERAGE OF RURAL HEALTH CLINIC AND FQHC SERVICES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark equivalent coverage under this section unless—

(A) the individual has access, through such coverage or otherwise, to services described in subparagraphs (B) and (C) of section 1905(a)(2); and

(B) payment for such services is made in accordance with the requirements of section 1902(bb).

(5) MINIMUM STANDARDS.—Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act. *This paragraph shall not apply after December 31, 2019.*

(6) MENTAL HEALTH SERVICES PARITY.—

(A) IN GENERAL.—In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a medicaid managed care organization and that provides both medical and surgical benefits and mental health

or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

(B) DEEMED COMPLIANCE.—Coverage provided with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), shall be deemed to satisfy the requirements of subparagraph (A).

(7) COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

(c) PUBLICATION OF PROVISIONS AFFECTED.—With respect to a State plan amendment to provide benchmark benefits in accordance with subsections (a) and (b) that is approved by the Secretary, the Secretary shall publish on the Internet website of the Centers for Medicare & Medicaid Services, a list of the provisions of this title that the Secretary has determined do not apply in order to enable the State to carry out the plan amendment and the reason for each such determination on the date such approval is made, and shall publish such list in the Federal Register and not later than 30 days after such date of approval.

* * * * *

TITLE XXII—PATIENT AND STATE STABILITY FUND

SEC. 2201. ESTABLISHMENT OF PROGRAM.

There is hereby established the “Patient and State Stability Fund” to be administered by the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as the “Administrator”), to provide funding, in accordance with this title, to the 50 States and the District of Columbia (each referred to in this section as a “State”) during the period, subject to section 2204(c), beginning on January 1, 2018, and ending on December 31, 2026, for the purposes described in section 2202.

SEC. 2202. USE OF FUNDS.

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

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

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

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

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

(5) *Promoting access to preventive services; dental care services (whether preventive or medically necessary); vision care services (whether preventive or medically necessary); prevention, treatment, or recovery support services for individuals with mental or substance use disorders; 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; DEFAULT SAFEGUARD.

(a) ENCOURAGING STATE OPTIONS FOR ALLOCATIONS.—

(1) *IN GENERAL.—To be eligible for an allocation of funds under this title for a year during the period described in section 2201 for use for one or more purposes described in section 2202, a State shall submit to the Administrator an application at such time (but, in the case of allocations for 2018, not later than 45 days after the date of the enactment of this title and, in the case of allocations for a subsequent year, not later than March 31 of the previous year) and in such form and manner as specified by the Administrator and containing—*

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

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

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

(2) *AUTOMATIC APPROVAL.—An application so submitted is approved unless the Administrator notifies the State submitting the application, not later than 60 days after the date of the submission of such application, that the application has been de-*

nied for not being in compliance with any requirement of this title and of the reason for such denial.

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

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

(b) *DEFAULT FEDERAL SAFEGUARD.*—

(1) *IN GENERAL.*—

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

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

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

SEC. 2204. ALLOCATIONS.

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

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

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

- (3) for 2020, \$10,000,000,000;
- (4) for 2021, \$10,000,000,000;
- (5) for 2022, \$10,000,000,000;
- (6) for 2023, \$10,000,000,000;
- (7) for 2024, \$10,000,000,000;
- (8) for 2025, \$10,000,000,000; and
- (9) for 2026, \$10,000,000,000.

(b) *ALLOCATIONS.*—

(1) *PAYMENT.*—

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

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

- (i) for 2018, the date that is 45 days after the date of the enactment of this title; and
- (ii) for 2019 and subsequent years, January 1 of the respective year.

(2) *ALLOCATION AMOUNT DETERMINATIONS.*—

(A) *FOR 2018 AND 2019.*—

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

- (I) the relative incurred claims amount described in clause (ii) for such State and year; and
- (II) the relative uninsured and issuer participation amount described in clause (iv) for such State and year.

(ii) *RELATIVE INCURRED CLAIMS AMOUNT.*—For purposes of clause (i), the relative incurred claims amount described in this clause for a State for 2018 and 2019 is the product of—

- (I) 85 percent of the amount appropriated under subsection (a) for the year; and
- (II) the relative State incurred claims proportion described in clause (iii) for such State and year.

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

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

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

(iv) *RELATIVE UNINSURED AND ISSUER PARTICIPATION AMOUNT.*—For purposes of clause (i), the relative uninsured and issuer participation amount described in

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

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

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

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

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

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

(aa) the number of individuals residing in such State who for the third preceding year were not enrolled in a health plan or otherwise did not have health insurance coverage (including through a Federal or State health program) and whose income is below 100 percent of the poverty line applicable to a family of the size involved; to

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

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

(I) The number of individuals residing in such State and described in clause (v)(II)(aa) was higher in 2015 than 2013.

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

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

(i) takes into consideration the adjusted incurred claims of such State, the number of residents of such State who for the previous year were not enrolled in a health plan or otherwise did not have health insurance coverage (including through a Federal or State health program) and whose income is below 100 percent of the poverty line applicable to a family of the size involved, and the number of health insurance issuers participating in the insurance market in such State for such year;

(ii) is established after consultation with health care consumers, health insurance issuers, State insurance

commissioners, and other stakeholders and after taking into consideration additional cost and risk factors that may inhibit health care consumer and health insurance issuer participation; and

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

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

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

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

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

(B) for States for which allocations were made pursuant to section 2203(b) for such previous year, to be used by the Administrator for such States, to carry out the purpose described in section 2202(2) in such States by providing payments to appropriate entities described in such section with respect to claims that exceed \$1,000,000;

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

(d) **AVAILABILITY.**— *Amounts appropriated under subsection (a) for a year and allocated to States in accordance with this section shall remain available for expenditure through December 31, 2027.*

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

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

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

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

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

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

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

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

- (G) for 2026, 50 percent of the amount allocated under this subsection to such State for such year and purpose;
- (2) in the case of an allocation that would be made for a State pursuant to section 2203(b), if the State does not agree that the State will make available non-Federal contributions towards such purpose in an amount equal to—
- (A) for 2020, 10 percent of the amount allocated under this subsection to such State for such year and purpose;
- (B) for 2021, 20 percent of the amount allocated under this subsection to such State for such year and purpose; and
- (C) for 2022, 30 percent of the amount allocated under this subsection to such State for such year and purpose;
- (D) for 2023, 40 percent of the amount allocated under this subsection to such State for such year and purpose;
- (E) for 2024, 50 percent of the amount allocated under this subsection to such State for such year and purpose;
- (F) for 2025, 50 percent of the amount allocated under this subsection to such State for such year and purpose; and
- (G) for 2026, 50 percent of the amount allocated under this subsection to such State for such year and purpose; or
- (3) if such an allocation for such purpose would not be permitted under subsection (c)(7) of section 2105 if such allocation were payment made under such section.

PUBLIC HEALTH SERVICE ACT

* * * * *

TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

PART A—INDIVIDUAL AND GROUP MARKET REFORMS

Subpart I—General Reform

SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS.

(a) PROHIBITING DISCRIMINATORY PREMIUM RATES.—

(1) IN GENERAL.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

(A) such rate shall vary with respect to the particular plan or coverage involved only by—

(i) whether such plan or coverage covers an individual or family;

(ii) rating area, as established in accordance with paragraph (2);

(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)) or, for plan years beginning on or after January 1, 2018, as the Secretary may implement through

interim final regulation, 5 to 1 for adults (consistent with section 2707(c)) or such other ratio for adults (consistent with section 2707(c)) as the State involved may provide; and

(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

(B) **such rate** subject to section 2710A, such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

(2) **RATING AREA.**—

(A) **IN GENERAL.**—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

(B) **SECRETARIAL REVIEW.**—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

(3) **PERMISSIBLE AGE BANDS.**—The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

(4) **APPLICATION OF VARIATIONS BASED ON AGE OR TOBACCO USE.**—With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

(5) **SPECIAL RULE FOR LARGE GROUP MARKET.**—If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all coverage offered in such market (other than self-insured group health plans offered in such market) in the State.

* * * * *

SEC. [2709] 2710. DISCLOSURE OF INFORMATION.

(a) **DISCLOSURE OF INFORMATION BY HEALTH PLAN ISSUERS.**—In connection with the offering of any health insurance coverage to a small employer or an individual, a health insurance issuer—

(1) shall make a reasonable disclosure to such employer,, or individual, as applicable, as part of its solicitation and sales materials, of the availability of information described in subsection (b), and

(2) upon request of such a employer, or individual, as applicable,, or individual, as applicable, provide such information.

(b) **INFORMATION DESCRIBED.**—

(1) **IN GENERAL.**—Subject to paragraph (3), with respect to a health insurance issuer offering health insurance coverage to a employer, or individual, as applicable,, information described in this subsection is information concerning—

(A) the provisions of such coverage concerning issuer’s right to change premium rates and the factors that may affect changes in premium rates; and

(B) the benefits and premiums available under all health insurance coverage for which the employer, or individual, as applicable, is qualified.

(2) **FORM OF INFORMATION.**—Information under this subsection shall be provided to employers, or individuals, as applicable, in a manner determined to be understandable by the average employer, or individual, as applicable,, and shall be sufficient to reasonably inform employers, or individuals, as applicable, of their rights and obligations under the health insurance coverage.

(3) **EXCEPTION.**—An issuer is not required under this section to disclose any information that is proprietary and trade secret information under applicable law.

SEC. 2710A. 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, such as a return or statement made under section 6055(d) or 36 of the Internal Revenue Code of 1986), during the look-back period that is with respect to such enforcement period, there was not a period of at least 63 continuous days during which the indi-

vidual 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.

* * * * *

MINORITY VIEWS

Committee Democrats adamantly and unanimously oppose the Committee's Reconciliation recommendations. Democrats voted in opposition to the Reconciliation recommendations during their consideration in the Committee on March 8 through March 9, 2017. We believe the recommendations will rip coverage away from millions, weaken consumer protections, and increase costs, particularly for older and sicker Americans. The recommendations raise costs for working families in order to provide billions of dollars in tax cuts to the wealthiest individuals and corporations. The legislative recommendations drastically alter the structure of the Medicaid program by harshly cutting federal funding, capping benefits, and ultimately shifting enormous costs to the states. We believe the recommendations would turn back the clock on efforts to transform the United States health care system from a system based on the treatment of disease to a system based on disease prevention. The Reconciliation instructions would also harm women's health and place politicians between women and their trusted health care provider by restricting access to the quality health services provided by Planned Parenthood.

The combination of Medicaid cuts, ending the Medicaid expansion, and providing less generous financial assistance for low and moderate income Americans to purchase health insurance in the individual market will result in millions of Americans losing health insurance coverage. Although the nonpartisan Congressional Budget Office (CBO) did not provide an analysis or score prior to the markup, independent estimates suggest that the repeal legislation could result in 15 million or more Americans losing coverage.¹ This legislation will leave Americans less healthy, less financially secure, and less able to access the healthcare they need.

Despite the wide-ranging, serious implications of this legislation for the health and financial security of all Americans, the Committee did not hold a single hearing on the details and effect of the legislation. Notably, stakeholders have not had the ability to weigh in on the impacts of the bill to the health care system. In fact, the Committee received letters from hospitals, doctors, and patient and advocacy groups all outlining their significant concerns with the legislation. Additionally, despite Speaker Ryan's claims that the bill would be considered through regular order and through a transparent process, the repeal bill was drafted in secret and introduced less than two days before markup. The minority is deeply concerned by the decision to proceed to markup without first receiving the views of the CBO on the impact of this legislation on health insurance coverage, costs, and the federal budget. Given the

¹Loren Adler and Matthew Fiedler, *Expect the CBO to estimate large coverage losses from the GOP health care plan*, Brookings Institution (Mar. 9, 2017).

likelihood that millions of Americans will lose their health insurance as a result of this legislation, proceeding to markup without a CBO score is highly irresponsible and deprives Committee members of a full understanding of the implications of the legislation before voting on it.

ELIMINATING THE PREVENTION AND PUBLIC HEALTH FUND WILL HARM EFFORTS TO BEND THE COST CURVE AND IMPROVE AMERICA'S HEALTH

The Reconciliation recommendations would repeal the Prevention and Public Health Fund (Prevention Fund) and rescind \$15.1 billion from fiscal year 2019 through fiscal year 2028, and \$2 billion each year thereafter. As a result, that funding would not be available to invest in critical preventive and public health programs such as efforts to reduce tobacco use, increase physical activity, expand mental health and injury prevention, and improve nutrition. The Prevention Fund is needed to invest in these types of efforts that bend the cost curve and improve America's health through the prevention and control of chronic disease.

Today in America, chronic disease, such as heart disease, diabetes, and cancer, are among the nation's most common, costly, and preventable health problems. Unsurprisingly, spending on chronic disease alone accounts for roughly 86 percent of all health care expenditures in the United States.² Chronic diseases also take a toll on American lives. In fact, chronic diseases account for 7 out of 10 deaths in the United States. Yet, despite the harms caused by chronic diseases, only a small percentage of government health expenditures are directed at preventing these diseases before they happen.

The Prevention Fund is the federal government's only dedicated investment in prevention and the nation's largest single investment in prevention. Since its creation, most Prevention Fund dollars have gone directly to states, communities, and tribal community organizations to improve the health and wellness of Americans. It has funded such programs as the highly successful *Tips from Former Smokers* national campaign. A recent study published in the *Lancet* found that the first three months of the national ad campaign led an estimated 1.6 million smokers to attempt to quit smoking and helped more than 100,000 Americans quit smoking permanently.³ Another study published in the *American Journal of Preventive Medicine* found that the campaign prevented more than 17,000 premature deaths in the United States.⁴

In addition to improving health, we know such investments save money. According to a study by Trust for America's Health, every \$1 spent on proven, community-based interventions to increase physical activity, improve nutrition, and prevent smoking—gen-

² Centers for Disease Control and Prevention (CDC), *Chronic Disease Prevention and Health Promotion* (Nov. 2016) (<https://www.cdc.gov/chronicdisease/index.htm>).

³ Tim McAfee, et al, *Effect of the First Federally Funded US Antismoking National Media Campaign*, *The Lancet* (Sept. 9, 2013).

⁴ Xin Xu, et al, *A Cost-Effectiveness Analysis of the First Federally Funded Antismoking Campaign*, *American Journal of Preventive Medicine* (Dec. 9, 2014).

erates a return of \$5.60.⁵ A study by the Urban Institute estimates that proven community-based diabetes prevention programs can save as much as \$191 billion over 10 years.⁶ Another study by Trust for America's Health found that a reduction of body mass index rates by 5 percent would save over \$158 billion in 10 years and almost \$612 billion in 20 years.⁷ Those are just some of the types of programs we invest in through the Prevention Fund.

Bending the United States health care cost curve and improving America's health demands that we expand rather than eliminate prevention efforts. Unfortunately, the Republican plan does the opposite. The Republican plan will eliminate the Prevention Fund's dedicated investment in prevention efforts and limit our ability to prevent and control chronic disease. Thus rather than save money and lives, the Republican plan will cost us more in the end.

DENYING FUNDING TO PLANNED PARENTHOOD RESTRICTS WOMEN'S ACCESS TO ESSENTIAL PREVENTIVE CARE AND BLOCKS PATIENTS FROM THEIR PROVIDERS OF CHOICE

The Reconciliation recommendations deny mandatory funding to Planned Parenthood for one year, including reimbursements from Medicaid, as well as funding provided through the Children's Health Insurance Program, Maternal and Child Health Services Block Grants, and Social Services Block Grants. While the bill notably does not mention Planned Parenthood by name, it denies funding to a designated class of providers that appear to be only applicable to Planned Parenthood-affiliated health centers. When questioned whether other providers could be subject to the bill, majority counsel was unable to specifically name any other providers besides Planned Parenthood that would meet these criteria.

As a result, millions of patients could lose access to essential care based solely on Republicans' ideological opposition to abortion, despite Planned Parenthood already receiving no federal funding for abortion services provided at some affiliated health centers.

Denying Medicaid reimbursements and other funding to Planned Parenthood would restrict patients' access to quality preventive care services, including screenings for breast and cervical cancer, sexually transmitted infection (STI) screenings, and contraception counseling and care. In 2014, Planned Parenthood-affiliated health centers saw 2.5 million patients and provided more than 4 million STI tests and treatments, more than 360,000 breast exams, more than 270,000 Pap tests, and contraception for over 2 million people.⁸ These services help to further the public health goals of detecting cancer, stopping the spread of STIs, and preventing unintended pregnancy.

While the Reconciliation recommendations provide additional funding to other safety-net providers, specifically community health

⁵Trust for America's Health, *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities* (Feb. 2009) (<http://healthyamericans.org/reports/prevention08/Prevention08.pdf>).

⁶Urban Institute, *How We Can Play for Health Care Reform* (July 29, 2009) (<http://www.urban.org/research/publication/how-we-can-pay-health-reform>).

⁷Trust for America's Health, *Bending the Obesity Cost Curve* (Feb. 2012) (<http://healthyamericans.org/report/93/>).

⁸Planned Parenthood Federation of America, *2014-2015 Annual Report*, 28 (https://www.plannedparenthood.org/files/2114/5089/0863/2014-2015_PPFA_Annual_Report_.pdf).

centers, experts agree that community health centers cannot fill the gap in care if funding is denied to Planned Parenthood. One public health expert noted that “the assertion that community health centers could step into a breach of this magnitude is simply wrong and displays a fundamental misunderstanding of how the health care system works.”⁹ Additionally, CBO previously estimated that 15 percent of Planned Parenthood’s patient population, or roughly 390,000 patients, would lose access to care if affiliated health centers were denied federal funding, and up to an additional 25 percent of individuals, or approximately 650,000 patients, could face reduced access.¹⁰

Approximately 60 percent of the patients served by Planned Parenthood receive benefits through public health coverage programs, including Medicaid.¹¹ Under federal law, Medicaid beneficiaries generally have the right to obtain medical services “from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide . . . such services.”¹² For decades, this “any willing provider” provision has served as a cornerstone of the Medicaid program and has ensured that patients enrolled in Medicaid are afforded the same basic rights and privileges as those with private coverage when choosing from whom to receive covered health services, including family planning and reproductive health care. The bill reneges on this principle and contradicts longstanding guidance and law prohibiting discrimination against certain providers based on reasons other than their ability to perform the required services.¹³

Denying funds to Planned Parenthood solely for ideological reasons separate than the ability to provide care harms patients and restricts women from making their own health care decisions about where to access care and from what provider. This bill sets a dangerous precedent, and will lead to a reduction in access to care and services provided for millions of women, men, and adolescents.

RATIONING CARE FOR MILLIONS OF AMERICANS RECEIVING COVERAGE THROUGH THE MEDICAID PROGRAM

Repeal of the Medicaid expansion

The Reconciliation legislation effectively ends the Medicaid expansion in its current form. While current Medicaid expansion enrollees would be grandfathered in at the higher matching rate, as of 2020, no new states would be allowed to expand, and states would lose the higher matching rate for any enrollees who had a break in coverage. Essentially, this ends the Medicaid expansion

⁹Sara Rosenbaum, *Planned Parenthood, Community Health Centers, and Women’s Health: Getting the Facts Right*, Health Affairs Blog (Sept. 2, 2015) (<http://healthaffairs.org/blog/2015/09/02/planned-parenthood-community-health-centers-and-womens-health-getting-the-facts-right/>).

¹⁰Congressional Budget Office, *Cost Estimate, H.R. 3762 Restoring Americans’ Healthcare Freedom Reconciliation Act of 2015* (Oct. 20, 2015) (<https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762.pdf>).

¹¹Planned Parenthood Federation of America, *The Urgent Need for Planned Parenthood Health Centers* (https://www.plannedparenthood.org/files/4314/8183/5009/20161207_Defunding_fs_d01_1.pdf).

¹²Social Security Act, § 1902(a)(23).

¹³Centers for Medicare and Medicaid Services, *Re: Clarifying “Free Choice of Provider” Requirement in Conjunction with State Authority to Take Action against Medicaid Providers* (Apr. 19, 2016).

through attrition. States that had taken a step forward to cover uninsured residents would be punished with cuts to their Medicaid disproportionate share hospital (DSH) payments for a period of two years. This policy will hurt millions of the lowest income residents, and negatively impact many of our state economies.

Rolling back the Medicaid expansion will result in a loss of coverage for many of the nation's lowest income, working, individuals. Currently, 31 states and the District of Columbia have expanded their Medicaid programs.¹⁴ Because of the Medicaid expansion, more than 14 million individuals have gained coverage, 11 million of which would not have been able to access coverage prior to the passage of Affordable Care Act (ACA).¹⁵ This new coverage, combined with coverage expansions through the Marketplaces and other coverage improvements the ACA made, has helped drive the uninsured rate to below 9 percent—the lowest level in our nation's history.¹⁶ It is undeniable that Medicaid expansion serves a critical role to provide health insurance to those who otherwise could not afford it and would remain uninsured.

Moreover, Medicaid provides high quality coverage that improves the lives of its beneficiaries. For individuals gaining coverage because of the Medicaid expansion, access to primary care and treatment for chronic conditions have increased, and rates of skipping medications to save money have decreased.¹⁷ Medicaid expansion has led to as much as a \$1,000-per-person reduction in medical debt sent to collection, and hospitals have seen their uncompensated-care burden drop by \$10 billion.¹⁸ Medicaid expansion has improved the affordability of care, with the number of low-income adults reporting problems paying medical bills down more than 10 percentage points,¹⁹ and 86 percent of new Medicaid enrollees were optimistic about their new health insurance's ability to connect them to the health care they need.²⁰ Medicaid has made a difference in the lives of millions; the overwhelming majority of those gaining coverage because of the expansion have said they were better off than before they received Medicaid.²¹

Rolling back the Medicaid expansion means rolling back gains made in state economies and local jobs. Evidence from states that have expanded Medicaid consistently shows that expansion generates savings and revenue which can be used to finance other state spending priorities or to offset much, if not all, of the state costs of expansion. Medicaid expansion states see more jobs in the health sector. On average, the states that expanded Medicaid in January 2014 saw jobs grow by 2.4 percent during 2014, while jobs

¹⁴ Kaiser Family Foundation, *Medicaid Expansion Enrollment* (2015) (<http://kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0>).

¹⁵ *Id.*

¹⁶ Letter from Andy M. Slavitt, Acting Administrator, Centers for Medicare and Medicaid Services (CMS) to Representative Tim Murphy (Jan. 18, 2017).

¹⁷ Benjamin D. Sommers, et al, *Changes in utilization and health among low-income adults after Medicaid expansion or expanded private insurance*, JAMA Internal Medicine (Oct. 2016) (<https://www.ncbi.nlm.nih.gov/pubmed/27532694>).

¹⁸ White House Council of Economic Advisers, *The Economic Record of the Obama administration: Reforming the Health Care System* (Dec. 2016).

¹⁹ Letter from Andy M. Slavitt, Acting Administrator, Centers for Medicare & Medicaid Services (CMS) to Representative Tim Murphy (Jan. 18, 2017).

²⁰ The Commonwealth Fund, *Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction* (May 25, 2016) (<http://www.commonwealthfund.org/publications/issue-briefs/2016/may/aca-tracking-survey-access-to-care-and-satisfaction>).

²¹ *Id.*

in states that did not expand grew by only 1.8 percent in the same year.²² Coverage expansions are contributing to a national reduction in hospital uncompensated care costs. Hospitals' uncompensated care costs are estimated to have been \$7.4 billion (21 percent) less in 2014 than they would have been in the absence of coverage expansions. In 2014, expansion states saw a reduction in uncompensated care costs of 26 percent, compared to a 16 percent reduction in non-expansion states.²³ It is worth noting that state Medicaid spending grew more slowly in states that expanded than in those that did not. State Medicaid spending in expansion states grew by half as much as spending in non-expansion states.²⁴ Medicaid expansion has been a good deal both for the individuals gaining coverage, and for the financial bottom line of states that have chosen to provide that coverage.

Capping the Medicaid Program

The Reconciliation legislation would fundamentally alter the current Medicaid funding structure, adopting a per capita cap per beneficiary construct that will be applied starting in FY 2019, but penalizing states beginning in 2020. The policy was drafted with no opportunity for comment from key stakeholders. This is not acceptable consideration for irrevocably changing the health insurance that more than 76 million Americans, the vast majority of them children, seniors, and individuals with disabilities, depend on. The hasty consideration of this legislation shows: key implementation questions remain from the drafting of this provision and further, whether states can even reasonably effectuate such a policy if enacted, in what amounts to less than two years' time. The consequences of enactment of this policy as drafted will be disastrous.

Under this legislation, it has been estimated that Medicaid costs per beneficiary could rise by about 0.2 percentage points faster each year than states' capped amounts; thus states would get less federal funding than under current law, with the cuts growing each year. This policy is a cost shift to states, at the expense of our most vulnerable. Under this policy, states would be responsible for 100 percent of any costs in excess of the per capita cap, whether due to unanticipated health care cost growth or to demographic changes that a per capita cap wouldn't account for. For example, states would be responsible for all costs due to an epidemic, a new treatment, or higher costs as seniors on Medicaid move from young-old age to old-old age and have much greater medical and long-term care needs and costs. In response, states would have to contribute more of their own funding or, as is far likelier, substantially cut eligibility, benefits, and provider payments, with those cuts growing more severe each year. Along with those who have gained coverage under the Medicaid expansion who would lose it under this legislation, the remaining 63 million children, families, seniors, and peo-

²²Families USA, *Medicaid Expansion States See Financial Savings and Health Care Jobs Growth* (Mar. 2015) (<http://familiesusa.org/blog/2015/03/medicaid-expansion-states-see-financial-savings-and-health-care-jobs-growth>).

²³Office of the Assistant Secretary for Planning and Evaluation (ASPE), *Economic Impact of the Medicaid Expansion* (Mar. 23, 2015) (https://aspe.hhs.gov/sites/default/files/pdf/139231/ib_MedicaidExpansion.pdf).

²⁴Kaiser Family Foundation, *Medicaid Enrollment & Spending Growth: FY 2015 & 2016* (Oct. 2015) (<http://kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2015-2016/>).

ple with disabilities who rely on Medicaid today would face the significant risk of ending up uninsured or losing access to needed care.

This policy is predicated on the concept that Medicaid costs are somehow unsustainable, when, in reality, Medicaid is the leanest of the federal health programs. This is due, in part, to many states' efforts around delivery system reform effectuating global reduction in costs while still improving the quality of care beneficiaries receive. States need the flexible financing construct that Medicaid has today in order to continue to design and implement such innovations in the future. Medicaid's current financing structure incentivizes and supports states to redesign the delivery system in ways that are better for their beneficiaries, and for state fiscal health.

Capping the Medicaid program and rationing care is the wrong way to ensure Medicaid's long-term financial health. Over the past 30 years, Medicaid costs per beneficiary have essentially tracked costs in the health care system as a whole, public and private. In fact, Medicaid has controlled per enrollee costs better than other payers. The per enrollee cost of Medicaid coverage grew 1.9 percent annually between 2000 and 2014, as compared to 5.9 percent growth in private coverage and 5.1 percent in Medicare.²⁵ Congress should build on successful state and federal efforts that have led to positive outcomes for both the program's financial health and care for beneficiaries.

Repeal of the Essential Health Benefits for the Medicaid expansion population

This legislation will repeal the Essential Health Benefit package for the Medicaid expansion population. Under Section 1902(k)(1) of the Social Security Act, states are required to offer newly eligible/expansion Medicaid beneficiaries "benchmark benefits." Further, Section 1937(b)(5) enumerates that benchmark benefits must meet the essential health benefits (EHB) requirements.²⁶ Today, in practice, the Essential Health Benefits (EHB) represent a minimum base assurance of benefits covered for the Medicaid Expansion population. Many states, given the robust federal participation in the expansion population, have chosen to design benefit packages that go beyond the basic benchmark.²⁷ However, the repeal of this basic protection of benefits, coupled with the changes made to slowly end the federal financial commitment to the Medicaid expansion wholesale over time means that states will most likely respond with sharp reductions in benefits to vulnerable beneficiaries.

Presumptive Eligibility repeal

The bill eliminates the state option for Presumptive Eligibility (PE) for the Medicaid expansion population and repeals the ability

²⁵Centers for Medicare and Medicaid Services, *National Health Expenditure Accounts and MACPAC, Trends in Medicaid Spending*.

²⁶Centers for Medicare and Medicaid Services, *Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment* (CMS-2334-F) (July 15, 2013).

²⁷The Commonwealth Fund, *Medicaid Benefit Designs for Newly Eligible Adults: State Approaches* (May 11, 2015) (<http://www.commonwealthfund.org/publications/issue-briefs/2015/may/medicaid-benefit-designs-for-newly-eligible-adults>).

of hospitals to determine Presumptive Eligibility in Medicaid. Presumptive Eligibility makes the enrollment process easier for eligible people and gets them the care they need immediately, which is more efficient, saves money and can save lives. We oppose the repeal of such policies.

Presumptive Eligibility is a longstanding state policy option in the Medicaid and Children's Health Insurance (CHIP) programs, which allows individuals who appear eligible to be enrolled quickly and begin receiving vital services while the full eligibility determination process is being completed. Presumptive eligibility allows individuals to begin receiving crucial health care services right away. It helps avert situations in which an individual who is eligible for Medicaid will have to delay needed care while they wait for their Medicaid application to be fully processed. Given that most PE determinations are made by health care providers while the person is present, forgoing the opportunity to deliver necessary care is highly inefficient. The missed opportunity to enroll the eligible person in Medicaid can result in significantly higher costs being incurred unnecessarily. Removing this option for the expansion population stigmatizes this population and delays needed care.

Moreover, hospital presumptive eligibility authority allows hospitals to temporarily enroll children, pregnant women, and other individuals in Medicaid until their full enrollment determination can be made. This policy has allowed hospitals to serve as a liaison between patients and state Medicaid programs to appropriately cover eligible individuals who would otherwise be uninsured, leading to poorer access to care for patients and higher uncompensated care for hospitals. This policy is particularly important for children; because hospitals are often the initial point of contact, they can help follow up to increase the likelihood that families complete the enrollment process for their uninsured children. This means earlier access to needed care for Medicaid eligible children, regardless of which state they live in. Outright repeal of this policy is problematic for all populations, however, and will result in additional barriers to individuals receiving the care they need.

Repeal of three-month retroactive coverage

The ACA allowed for a three-month look back period to cover individuals who were eligible, but not covered by Medicaid at the time of hospital admission. Ensuring retroactive coverage of benefits under Medicaid is very important for eligible individuals, including children with special health care needs and individuals with disabilities, who may have very high cost medical conditions. Retroactive coverage allows Medicaid to cover expenses for covered benefits in the three months prior to the month of application for individuals who are eligible for Medicaid. Without this provision, it would be challenging for families who incurred high levels of expense prior to being enrolled in the program even though they would have been eligible for Medicaid during that period of time. This provision is punitive and particularly harmful to very sick and/or high-need populations.

Repeal of alignment of children's coverage

The ACA aligned coverage for more than half a million low-income, school-aged children in 22 states that were previously covered under different programs.²⁸ Specifically, the ACA required that all states align the minimum threshold for Medicaid eligibility for all children under the age of 18 to 138 percent of the Federal Poverty Level (FPL). This legislation repeals this basic protection for children's coverage.

Prior to the ACA's passage, young children under age six with family incomes up to 138 percent of the FPL were covered in Medicaid, whereas children ages 6–18 were only required to be covered up to 100 percent FPL. While states had the option to align Medicaid eligibility levels for children of all ages at 133 percent FPL or higher, many instead placed the older children above the poverty line in separate CHIP. This created a 'stairstep' coverage structure in many states, where young children were in Medicaid while school-aged children, even in the same family, received coverage in separate CHIP programs.

The pediatric benefit in Medicaid—known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit—ensures children can receive the screenings they need to make sure their development is on track, and if any illnesses or delays are identified, that children receive the treatment they need to thrive. Under the proposed legislation, states would be able to strip this benefit from school-aged children (6–18 year olds) in families with incomes between 100–133 percent of poverty. States could also impose premiums and co-pays on this population, making it harder for school-aged children to access needed services. This provision is a step backwards for the health of low-income children.

Mandatory six-month redetermination for expansion population

The bill would institute a six-month redetermination requirement for the Medicaid expansion population. Requiring states to redetermine eligibility of beneficiaries eligible under the expansion every six months instead of once a year would cause adults to lose access to health care, would be costly and burdensome for states, and would make it harder for health care providers and managed care organizations to coordinate care for beneficiaries. Coupled with provisions in this legislation to end the enhanced match for the expansion in 2020, this provision is clearly designed to decrease enrollment of adults receiving the enhanced match and shift costs to states, who would have to contribute an estimated 2.8 to 5 times more to cover them.

The ACA changed Medicaid to a 12-month renewal cycle to limit "churn" between programs. States have multiple ways to ensure program integrity without requiring beneficiaries to submit paperwork every six months, such as checking unemployment and wage data, sharing data with the Supplemental Nutritional Assistance Program and other state programs. When these data sources suggest a Medicaid beneficiary is no longer eligible, states can follow

²⁸ Wesley Prater and Joan Alker, *Aligning Eligibility for Children: Moving the Stairstep Kids to Medicaid*, Kaiser Commission on Medicaid and the Uninsured (Aug. 2013) (<http://ccf.georgetown.edu/wp-content/uploads/2013/08/stair-step.pdf>).

up and request information from the beneficiary. Requiring 6-month renewals limits a state's flexibility to run their Medicaid program in a cost-effective and efficient manner by imposing burdensome and unnecessary mandates.

Repeal of Community First Choice match

The Community First Choice option was authorized by the ACA as part of a host of new options to incentivize states to rebalance their Medicaid long-term care programs toward home and community based care, helping to keep individuals in their homes and communities as long as possible. The "Community First Choice Option" allows States to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their state Plan, providing a 6 percentage point increase in federal matching payments to states for service expenditures related to this option. Services are provided statewide, with no enrollment caps. Currently, eight states provide this important option, yet this legislation would remove the federal support, resulting in hundreds of millions in cuts in funding for this important initiative to each state. This provision would incentivize states to drop this important program, endangering the service for the elderly and individuals with disabilities and moving the program backwards.

UNRAVELING HEALTH INSURANCE COVERAGE FOR MILLIONS OF AMERICANS AND FORCING THEM TO PAY MORE FOR LESS

The minority is opposed to this bill, because it will force Americans to pay more for less, by driving up costs for older Americans, increasing deductibles, and lowering financial assistance to purchase health insurance. The legislation implements an "age tax" that allows insurers to charge an older person five times more than a young person. The Affordable Care Act limited insurers to 3:1 age rating, thus requiring insurers to charge older Americans no more than three times more than younger Americans. This repeal legislation sets 5:1 age rating as the default, and would allow states to go beyond 5:1 to establish any age rating ratio they choose. This would raise older Americans' premiums by thousands of dollars a year.

The repeal bill also replaces the ACA's tax credits with a wholly inadequate flat tax credit based on age. The ACA's tax credits have made health insurance affordable for millions of lower and middle income Americans. In 2016, over 85 percent of consumers received an advance premium tax credit, which varies by an individual's income, family size, and the cost of premiums in the area in which they live. The repeal legislation will eliminate the ACA's premium assistance and replace them with tax credits that vary only by age. These tax credits will be substantially lower in value than the ACA's premium tax credits. Current enrollees would receive an average tax credit in 2020 that is 36 percent less than under the ACA, according to the Kaiser Family Foundation. Additionally, these tax credits would not keep pace with the cost of healthcare, as they are indexed to CPI plus one percent, unlike the ACA's tax credits, which are tied to the growth of insurance premiums. This coupled with changes to age rating will make health care unaffordable for older Americans.

The repeal bill also eliminates the ACA's cost-sharing subsidies, which lower out-of-pocket costs for low-income consumers below 250 percent of the federal poverty level and help families afford copays and deductibles when seeing their doctors. Cost-sharing reductions significantly lower out-of-pocket costs for consumers, and the majority's decision to eliminate them without replacing them with any equivalent financial assistance will profoundly impact the ability of low-income individuals to afford to use their health insurance.

The repeal bill fails to protect consumers, including up to 129 million Americans with pre-existing conditions. It undermines the ACA's protections for individuals with preexisting conditions by implementing a new, 30 percent surcharge on enrollees who have had a lapse in coverage. This "sick tax" will make coverage more expensive for consumers when they need it most. For instance, according to the American Cancer Society, cancer patients are likely to have gaps in coverage beyond their control and would therefore be disproportionately penalized by the continuous coverage requirement.

Additionally, the minority is concerned that millions of Americans will be unable to afford health insurance under the repeal legislation, and will therefore be subject to this sick tax. The lack of any hardship exemption whatsoever underscores the reality that the most vulnerable enrollees, such as the very sick and very low-income enrollees, will be disproportionately subject to this penalty. Low-income enrollees with serious medical conditions, such as chronic illnesses and disabilities, could find themselves permanently locked out of coverage.

Moreover, the policies in this bill will likely result in a "death spiral" in the ACA marketplaces, which will raise premiums even more for individuals with preexisting conditions. The continuous coverage penalty, while onerous to those who are sick and need care, is unlikely to incentivize healthy Americans to purchase coverage. Many economists, as well as health insurers, believe that the young and healthy will gamble, and will stay out of the market unless they get sick. As the young and healthy pull out of the pool, premiums will go up for those left in the individual market.

The repeal bill also repeals important consumer protections in the ACA that ensure that consumers get value for their health insurance. It eliminates the actuarial value requirements of the ACA, which require insurers to offer individual market plans that meet certain standards—bronze, silver, gold and platinum. Each actuarial value corresponds to an average value to the consumer—higher value plans have lower out-of-pocket costs (deductibles, coinsurance, and co-pays), while lower value plans have higher out-of-pocket costs. Repealing this requirement will send us back to the days before the ACA, when insurance companies provided bare bones plans that provided very little value for Americans' premium dollars. Insurance companies will no longer be required to offer a minimum level of benefits, resulting in skinnier plans with higher deductibles and higher cost-sharing.

This legislation creates an ill-defined and inadequate "Patient and State Stability Fund" with zero protections to ensure the funding helps consumers access health care. The bill allocates \$15 billion in 2018 and 2019 and \$10 billion each year until 2026; there

is no additional funding beyond this date. This small amount of funding is expected to be used for wide-ranging purposes such as high-risk pools, stabilizing insurance markets, provider payments, providing preventive care, and reducing premium costs for consumers. Majority members at the Committee markup further suggested that the funds could be used to solve the opioid epidemic, or to allow states to expand access to treatment for the mentally ill. The minority is concerned that the majority's aspirations for these limited dollars are not grounded in reality. Given that aggregate premiums in the individual insurance market are expected to be around \$175 billion in 2026 according to CBO, even if the full amount of the fund were used to reduce premiums, the overall impact for consumers would be limited. Additionally, there is no requirement that the funds actually reduce premiums and costs for consumers or expand coverage. Under the broad terms listed in the legislation, states could use the money to increase payments to providers under state health programs, build new hospitals or clinics, or provide flu shots. While important, none of these projects would necessarily increase access to affordable health insurance.

Finally, to the extent that states use these funds to set up high risk pools, the minority is concerned that quarantining the sickest patients in high risk pools is destined to fail and will not protect people with pre-existing conditions. Decades of experience with high-risk pools has proven that they do not work—they are expensive for states to administer, expensive for consumers to purchase, and offer poor coverage with high premiums and even higher deductibles. High risk pools were incredibly expensive for sick patients, sometimes charging up to 250 percent of what healthy patients paid for their health insurance. Deductibles were sometimes as high as \$25,000 with annual limits as low as \$75,000. Even with inadequate coverage and high deductibles, states still had difficulty funding high-risk pools, resulting in long waiting lists and the rationing of care for the sickest patients. Furthermore, as the repeal legislation has no federal standards or consumer protections associated with these state high risk pools, states would be free to impose annual and lifetime limits, coverage exclusions associated with a patient's pre-existing conditions, and waiting periods.

For all of these reasons, the Democratic Members of the Energy and Commerce Committee strongly oppose the Reconciliation bill.

SIGNATORIES

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Committee Print

Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act, As Adopted by the Committee on Energy and Commerce on March 9, 2017

TITLE I—ENERGY AND COMMERCE

Subtitle A—Patient Access to Public Health Programs

SEC. 101. THE PREVENTION AND PUBLIC HEALTH FUND.

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

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

(2) in paragraph (3)—

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

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

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

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

SEC. 102. COMMUNITY HEALTH CENTER PROGRAM.

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

SEC. 103. FEDERAL PAYMENTS TO STATES.

(a) IN GENERAL.—Notwithstanding section 504(a), 1902(a)(23), 1903(a), 2002, 2005(a)(4), 2102(a)(7), or 2105(a)(1) of the Social Security Act (42 U.S.C. 704(a), 1396a(a)(23), 1396b(a), 1397a, 1397d(a)(4), 1397bb(a)(7), 1397ee(a)(1)), or the terms of any Medicaid waiver in effect on the date of enactment of this Act that is approved under section 1115 or 1915 of the Social Security Act (42

U.S.C. 1315, 1396n), for the 1-year period beginning on the date of the enactment of this Act, no Federal funds provided from a program referred to in this subsection that is considered direct spending for any year may be made available to a State for payments to a prohibited entity, whether made directly to the 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)).

Subtitle B—Medicaid Program Enhancement

SEC. 111. REPEAL OF MEDICAID PROVISIONS.

The Social Security Act is amended—

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

(A) in subsection (a)(47)(B), by inserting “and provided that any such election shall cease to be effective on Janu-

ary 1, 2020, and no such election shall be made after that date” before the semicolon at the end; and

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

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

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

SEC. 112. REPEAL OF MEDICAID EXPANSION.

(a) IN GENERAL.—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 assist-

ance 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. 113. ELIMINATION OF DSH CUTS.

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

(1) in paragraph (7)—

(A) in subparagraph (A)—

(i) in clause (i)—

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

(ii) in clause (ii)—

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

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

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

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

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

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

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

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

“(I) The term ‘expansion State’ means with respect to a fiscal year, a State that, as of July 1 of the preceding fiscal year, provides for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) for medical assistance under this title (or a waiver of the State plan approved under section 1115).

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

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

SEC. 114. REDUCING STATE MEDICAID COSTS.

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

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

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

(B) in subsection (e)—

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

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

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

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

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

“(III) over a period of 3 months if the amount of such winnings or income (as applicable) is greater than or equal to \$90,000 but less than \$100,000; and

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

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

“(iii) HARDSHIP EXEMPTION.—An individual whose income, by application of clause (i), exceeds the applicable eligibility threshold established by the State, may continue to be eligible for medical assistance to the extent that the State determines, under procedures established by the State under the State plan (or in the case of a waiver of the plan under section 1115, incorporated in such waiver), or as otherwise established by such State in accordance with such stand-

ards as may be specified by the Secretary, that the denial of eligibility of the individual would cause an undue medical or financial hardship as determined on the basis of criteria established by the Secretary.

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

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

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

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

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

(ii) by striking “(14) EXCLUSION” and inserting “(15) EXCLUSION”.

(2) RULES OF CONSTRUCTION.—

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

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

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

(b) REPEAL OF RETROACTIVE ELIGIBILITY.—

(1) IN GENERAL.—

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

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

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

(c) ENSURING STATES ARE NOT FORCED TO PAY FOR INDIVIDUALS INELIGIBLE FOR THE PROGRAM.—

(1) IN GENERAL.—Section 1137(f) of the Social Security Act (42 U.S.C. 1320b–7(f)) is amended—

(A) by striking “Subsections (a)(1) and (d)” and inserting “(1) Subsections (a)(1) and (d)”; and

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

“(2)(A) Subparagraphs (A) and (B)(ii) of subsection (d)(4) shall not apply in the case of an initial determination made on or after the date that is 6 months after the date of the enactment of this paragraph with respect to the eligibility of an alien described in subparagraph (B) for benefits under the program listed in subsection (b)(2).”

“(B) An alien described in this subparagraph is an individual declaring to be a citizen or national of the United States with respect to whom a State, in accordance with section 1902(a)(46)(B), requires—

“(i) pursuant to 1902(ee), the submission of a social security number; or

“(ii) pursuant to 1903(x), the presentation of satisfactory documentary evidence of citizenship or nationality.”.

(2) NO PAYMENTS FOR MEDICAL ASSISTANCE PROVIDED BEFORE PRESENTATION OF EVIDENCE.—Section 1903(i)(22) of the Social Security Act (42 U.S.C. 1396b(i)(22)) is amended—

(A) by striking “with respect to amounts expended” and inserting “(A) with respect to amounts expended”;

(B) by inserting “and” at the end; and

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

“(B) in the case of a State that elects to provide a reasonable period to present satisfactory documentary evidence of such citizenship or nationality pursuant to paragraph (2)(C) of section 1902(ee) or paragraph (4) of subsection (x) of this section, for amounts expended for medical assistance for such an individual (other than an individual described in paragraph (2) of such subsection (x)) during such period;”.

(3) CONFORMING AMENDMENTS.—Section 1137(d)(4) of the Social Security Act (42 U.S.C. 1320b–7(d)(4)) is amended—

(A) in subparagraph (A), in the matter preceding clause (i), by inserting “subject to subsection (f)(2),” before “the State”; and

(B) in subparagraph (B)(ii), by inserting “subject to subsection (f)(2),” before “pending such verification”.

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

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

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

(B) by striking subparagraph (B);

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

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

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—The amendments made by paragraph (1) shall apply with respect to eligibility determinations made after the date that is 180 days after the date of the enactment of this section.

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

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

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

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

“SEC. 1923A. (a) IN GENERAL.—Subject to the limitations of this section, for each year during the period beginning with 2018 and

ending with 2021, each State that is one of the 50 States or the District of Columbia and that, as of July 1 of the preceding year, did not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) for medical assistance under this title (or a waiver of the State plan approved under section 1115) (each such State or District referred to in this section for the year as a ‘non-expansion State’) may adjust the payment amounts otherwise provided under the State plan under this title (or a waiver of such plan) to health care providers that provide health care services to individuals enrolled under this title (in this section referred to as ‘eligible providers’).

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

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

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

“(c) LIMITATIONS; DISQUALIFICATION OF STATES.—

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

“(A) the population of the State with income below 138 percent of the poverty line in 2015 (as determined based on the table entitled ‘Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age’ for the universe of the civilian noninstitutionalized population for whom poverty status is determined based on the 2015 American Community Survey 1-Year Estimates, as published by the Bureau of the Census), to

“(B) the sum of the populations under subparagraph (A) for all non-expansion States.

“(2) LIMITATION ON PAYMENT ADJUSTMENT AMOUNT FOR INDIVIDUAL PROVIDERS.—The amount of a payment adjustment under subsection (a) for an eligible provider may not exceed the provider’s costs incurred in furnishing health care services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) to individuals who either are eligible for medical assistance under the State plan (or under a waiver of such plan) or have no health insurance or health plan coverage for such services.

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

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

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

“(K) **FREQUENCY OF ELIGIBILITY REDETERMINATIONS.**—Beginning on October 1, 2017, and notwithstanding subparagraph (H), in the case of an individual whose eligibility for medical assistance under the State plan under this title (or a waiver of such plan) is determined based on the application of modified adjusted gross income under subparagraph (A) and who is so eligible on the basis of clause (i)(VIII) or clause (ii)(XX) of subsection (a)(10)(A), a State shall redetermine such individual’s eligibility for such medical assistance no less frequently than once every 6 months.”

(b) **CIVIL MONETARY PENALTY.**—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended, in the matter following paragraph (10), by striking “(or, in cases under paragraph (3))” and inserting the following: “(or, in cases under paragraph (1) in which an individual was knowingly enrolled on or after October 1, 2017, pursuant to section 1902(a)(10)(A)(i)(VIII) for medical assistance under the State plan under title XIX whose income does not meet the income threshold specified in such section or in which a claim was presented on or after October 1, 2017, as a claim for an item or service furnished to an individual described in such section but whose enrollment under such State plan is not made on the basis of such individual’s meeting the income threshold specified in such section, \$20,000 for each such individual or claim; in cases under paragraph (3))”.

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

Subtitle C—Per Capita Allotment for Medical Assistance

SEC. 121. PER CAPITA ALLOTMENT FOR MEDICAL ASSISTANCE.

Title XIX of the Social Security Act is amended—

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

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

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

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

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

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

“(1) IN GENERAL.—If a State has excess aggregate medical assistance expenditures (as defined in paragraph (2)) for a fiscal year (beginning with fiscal year 2020), the amount of payment to the State under section 1903(a)(1) for each quarter in the following fiscal year shall be reduced by $\frac{1}{4}$ 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:

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

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

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

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

“(c) TARGET TOTAL MEDICAL ASSISTANCE EXPENDITURES.—

“(1) CALCULATION.—In this section, the term ‘target total medical assistance expenditures’ means, for a State for a fiscal year, 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.

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

“(1) CALCULATION OF BASE AMOUNTS FOR FISCAL YEAR 2016.—

For each State the Secretary shall calculate (and provide notice to the State not later than April 1, 2018, of) the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“(I) is not made under section 1923;

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

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

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

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

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

“(C) For fiscal year 2016, the State’s non-DSH supplemental 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 subclause (XII) or (XXI) of section 1902(a)(10)(A)(ii) (or pursuant to a waiver that provides only comparable benefits);

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

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

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

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

“(B) BLIND AND DISABLED.—A category of 1903A enrollees (not described in the previous subparagraph) who are

eligible for medical assistance under this title on the basis of being blind or disabled.

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

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

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

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

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

“(f) SPECIAL PAYMENT RULES.—

“(1) APPLICATION IN CASE OF RESEARCH AND DEMONSTRATION PROJECTS AND OTHER WAIVERS.—In the case of a State with a waiver of the State plan approved under section 1115, section 1915, or another provision of this title, this section shall apply to medical assistance expenditures and medical assistance payments under the waiver, in the same manner as if such expenditures and payments had been made under a State plan under this title and the limitations on expenditures under this section shall supersede any other payment limitations or provisions (including limitations based on a per capita limitation) otherwise applicable under such a waiver.

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

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

“(A) the Secretary shall calculate and apply subsections (a) through (e) with respect to the State as if all 1903A enrollee categories for which such expenditure and enrollee data were not satisfactorily submitted were a single 1903A enrollee category; and

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

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

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

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

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

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

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

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

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

Subtitle D—Patient Relief and Health Insurance Market Stability

SEC. 131. REPEAL OF COST-SHARING SUBSIDY.

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

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

SEC. 132. PATIENT AND STATE STABILITY FUND.

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

“TITLE XXII—PATIENT AND STATE STABILITY FUND

“SEC. 2201. ESTABLISHMENT OF PROGRAM.

“There is hereby established the ‘Patient and State Stability Fund’ to be administered by the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as the ‘Administrator’), to provide funding, in accordance with this title, to the 50 States and the District of Columbia (each referred to in this section as a ‘State’) during the period, subject to section 2204(c), beginning on January 1, 2018, and ending on December 31, 2026, for the purposes described in section 2202.

“SEC. 2202. USE OF FUNDS.

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

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

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

“(3) Reducing the cost for providing health insurance coverage in the individual market and small group market, as such markets are defined by the State, to individuals who

have, or are projected to have, a high rate of utilization of health services (as measured by cost).

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

“(5) Promoting access to preventive services; dental care services (whether preventive or medically necessary); vision care services (whether preventive or medically necessary); prevention, treatment, or recovery support services for individuals with mental or substance use disorders; 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; DEFAULT SAFEGUARD.

“(a) ENCOURAGING STATE OPTIONS FOR ALLOCATIONS.—

“(1) IN GENERAL.—To be eligible for an allocation of funds under this title for a year during the period described in section 2201 for use for one or more purposes described in section 2202, a State shall submit to the Administrator an application at such time (but, in the case of allocations for 2018, not later than 45 days after the date of the enactment of this title and, in the case of allocations for a subsequent year, not later than March 31 of the previous year) and in such form and manner as specified by the Administrator and containing—

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

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

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

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

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

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

“(b) DEFAULT FEDERAL SAFEGUARD.—

“(1) IN GENERAL.—

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

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

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

“SEC. 2204. ALLOCATIONS.

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

“(1) for 2018, \$15,000,000,000;

“(2) for 2019, \$15,000,000,000;

“(3) for 2020, \$10,000,000,000;

“(4) for 2021, \$10,000,000,000;

“(5) for 2022, \$10,000,000,000;

“(6) for 2023, \$10,000,000,000;

“(7) for 2024, \$10,000,000,000;

“(8) for 2025, \$10,000,000,000; and

“(9) for 2026, \$10,000,000,000.

“(b) ALLOCATIONS.—

“(1) PAYMENT.—

“(A) IN GENERAL.—From amounts appropriated under subsection (a) for a year, the Administrator shall, with respect to a State and not later than the date specified under

subparagraph (B) for such year, allocate, subject to subsection (e), for such State (including pursuant to section 2203(b)) the amount determined for such State and year under paragraph (2).

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

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

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

“(2) ALLOCATION AMOUNT DETERMINATIONS.—

“(A) FOR 2018 AND 2019.—

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

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

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

“(ii) RELATIVE INCURRED CLAIMS AMOUNT.—For purposes of clause (i), the relative incurred claims amount described in this clause for a State for 2018 and 2019 is the product of—

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

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

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

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

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

“(iv) RELATIVE UNINSURED AND ISSUER PARTICIPATION AMOUNT.—For purposes of clause (i), the relative uninsured and issuer participation amount described in this clause for a State for 2018 and 2019 is the product of—

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

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

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

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

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

“(aa) the number of individuals residing in such State who for the third preceding year were not enrolled in a health plan or otherwise did not have health insurance coverage (including through a Federal or State health program) and whose income is below 100 percent of the poverty line applicable to a family of the size involved; to

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

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

“(I) The number of individuals residing in such State and described in clause (v)(II)(aa) was higher in 2015 than 2013.

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

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

“(i) takes into consideration the adjusted incurred claims of such State, the number of residents of such State who for the previous year were not enrolled in a health plan or otherwise did not have health insurance coverage (including through a Federal or State health program) and whose income is below 100 percent of the poverty line applicable to a family of the size involved, and the number of health insurance issuers participating in the insurance market in such State for such year;

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

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

“(c) ANNUAL DISTRIBUTION OF PREVIOUS YEAR’S REMAINING FUNDS.— In carrying out subsection (b), the Administrator shall,

with respect to a year (beginning with 2020 and ending with 2027), not later than March 31 of such year—

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

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

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

“(B) for States for which allocations were made pursuant to section 2203(b) for such previous year, to be used by the Administrator for such States, to carry out the purpose described in section 2202(2) in such States by providing payments to appropriate entities described in such section with respect to claims that exceed \$1,000,000;

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

“(d) AVAILABILITY.—Amounts appropriated under subsection (a) for a year and allocated to States in accordance with this section shall remain available for expenditure through December 31, 2027.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 133. CONTINUOUS HEALTH INSURANCE COVERAGE INCENTIVE.

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

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

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

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

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

“(a) PENALTY APPLIED.—

“(1) IN GENERAL.—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, such as a return or statement made under section 6055(d) or 36C of the Internal Revenue Code of 1986), during the look-back period that is with respect to such enforcement period, there was not a period of at least 63 continuous days during which the individual did not have creditable coverage (as defined in paragraph (1) of section 2704(c) and credited in accordance with paragraphs (2) and (3) of such section); and

“(C) in the case of an individual who had been enrolled under dependent coverage under a group health plan or health insurance coverage by reason of section 2714 and such dependent coverage of such individual ceased because of the age of such individual, is not enrolling during the first open enrollment period following the date on which such coverage so ceased.

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

“(3) ENFORCEMENT PERIOD.—The term ‘enforcement period’ means—

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

“(B) with respect to enrollments for plan year 2019 or a subsequent plan year, the 12-month period beginning on the first day of the respective plan year.”.

SEC. 134. INCREASING COVERAGE OPTIONS.

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

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

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

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

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

Section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)(iii)), as inserted by section 1201(4) of the Patient Protection and Affordable Care Act, is amended by inserting

after “(consistent with section 2707(c))” the following: “or, for plan years beginning on or after January 1, 2018, as the Secretary may implement through interim final regulation, 5 to 1 for adults (consistent with section 2707(c)) or such other ratio for adults (consistent with section 2707(c)) as the State involved may provide”.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC, March 13, 2017.

Hon. DIANE BLACK,
Chairman, Committee on the Budget,
Washington, DC.

DEAR CHAIRMAN BLACK: Pursuant to section 2002 of S. Con. Res. 3, the Fiscal Year 2017 Concurrent Resolution on the Budget, as well as section 310 of the Congressional Budget and Impoundment Control Act of 1974, I hereby transmit to the House Committee on the Budget these recommendations, which were approved by vote of the Committee Ways and Means on March 9, 2017, and the appropriate accompanying material, including dissenting views.

Sincerely,

KEVIN BRADY,
Chairman.

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SUBTITLE [A]—REPEAL AND REPLACE OF HEALTH-RELATED TAX POLICY

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

In fulfillment of the reconciliation instructions included in section 2002 of the Concurrent Resolution on the Budget for Fiscal Year 2017 (S. Con. Res. 3), the Committee on Ways and Means ordered favorably transmitted (with a quorum being present) the Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy. The Committee recommends modification for a transition period, followed by repeal, of the premium assistance tax credit and the small business tax credit under the Internal Revenue Code of 1986, as amended (“Code”);¹ repeal of various other taxes and tax increases imposed by the Patient Protection and Affordable Care Act of 2010 (“PPACA”), Pub. L. No. 111–148 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (“HCERA”), Pub. L. No. 111–152 (March 30, 2010);² enactment of a tax credit for the purchase of health insurance in the individual market by taxpayers who are not eligible for health coverage from other sources; and improvements to the rules governing health savings accounts.

B. BACKGROUND AND NEED FOR LEGISLATION

In the Committee’s pursuit of comprehensive health care reform to relieve unnecessary burdens on insurance markets, the broader economy, and taxpayers in need of access to quality health care, the Committee wishes to take immediate measures to stabilize insurance markets, provide relief from taxes imposing excessive constraints on choice and innovation, expand access to additional health insurance options, and encourage consumer awareness of health care costs and effectiveness. The Committee believes that transition modifications to the present-law premium assistance and small business tax credits, accompanied by the repeal of burdensome individual and business taxes and expansion of health savings accounts, in combination with replacement measures that expand health coverage choices, will further these goals.

C. LEGISLATIVE HISTORY

Budget resolution

On January 13, 2017, the House of Representatives approved S. Con. Res. 3, the budget resolution for fiscal year 2017. Pursuant to section 2002(a)(3) of S. Con. Res. 3, the Committee on Ways and

¹ All section references herein are to the Code unless otherwise stated.

² PPACA and HCERA are collectively referred to as the Affordable Care Act (“ACA”).

Means was directed to submit to the Committee on the Budget recommendations for changes in law within the jurisdiction of the Committee on Ways and Means sufficient to reduce the deficit by \$1,000,000,000 for the period of fiscal years 2017 through 2026.

Committee action

Beginning March 8, 2017, in response to its instructions under the budget resolution, the Committee on Ways and Means marked up the budget reconciliation legislative recommendations relating to repeal and replace of health-related tax policy and ordered the legislative recommendations, as amended, favorably transmitted (with a quorum being present) on March 9, 2017.

Committee hearings

Since the 112th Congress, the Committee on Ways and Means held a number of hearings on health reform that explored various parts of the health system and informed policy contained in the American Health Care Act. These hearings include:

Full Committee

- January 26, 2011—Hearing on the Health Care Law’s Impact on Jobs, Employers, and the Economy.
- February 16, 2011—Hearing on the President’s Fiscal Year 2012 Budget Proposal with US Department of Health and Human Services Secretary Kathleen Sebelius.
- February 28, 2012—Hearing on the President’s Fiscal Year 2013 Budget Proposal with HHS Secretary Kathleen Sebelius.
- July 10, 2012—Hearing on Tax Ramifications of the Supreme Court’s Ruling on the Democrats’ Health Care Law.
- April 12, 2013—The President’s Fiscal Year 2014 Budget Proposal with U.S. Department of Health and Human Services Secretary Kathleen Sebelius.
- October 29, 2013—Hearing on The Status of the Affordable Care Act Implementation.
- January 28, 2014—The Impact of the Employer Mandate’s Definition of Full-Time Employee on Jobs and Opportunities.
- March 6, 2014—The President’s Fiscal Year 2015 Budget Proposal with U.S. Department of the Treasury Secretary Jacob J. Lew.
- March 12, 2014—The President’s Fiscal Year 2015 Budget Proposal with U.S. Department of Health and Human Services Secretary Kathleen Sebelius.
- June 10, 2015—Hearing on Obamacare Implementation and the Department of Health and Human Services Fiscal Year 2016 Budget Request.
- February 10, 2016—Hearing on the Department of Health and Human Services Fiscal Year 2017 Budget Request.
- March 14, 2016—Hearing on the Tax Treatment of Health Care.

Health Subcommittee

- September 9, 2011—Hearing on Health Care Industry Consolidation.

- March 29, 2012—Hearing on the Individual and Employer Mandates in the Democrat's Health Care Law.
- September 12, 2012—Hearing on Implementation of Health Insurance Exchanges and Related Provisions.
- July 10, 2013—Hearing on The Delay of the Employer Mandate.
- July 17, 2013—Hearing on the Delay of the Employer Mandate Penalties and Reporting Requirements.
- December 4, 2013—Hearing on the Challenges of the Affordable Care Act.
- April 8, 2014—The Treasury Department's Final Employer Mandate and Employer Reporting Requirements Regulations.
- June 10, 2014—Verification of Income and Insurance Information Under the Affordable Care Act.
- September 10, 2014—Hearing on the Status of the Affordable Care Act Implementation.
- April 14, 2015—Hearing on the Individual and Employer Mandates in the President's Health Care Law.
- November 3, 2015—Hearing on the State of Obamacare's CO-OP Program.
- May 17, 2016—Member Day Hearing on Tax-related Proposals to Improve Health Care.
- September 14, 2016—Hearing on Exploring the Use of Technology and Innovation to Create Efficiencies and Higher Quality in Health Care.

Select Revenue Measures Subcommittee

- March 16, 2011—Hearing on Tax-Related Provisions of H.R. 3.

Human Resources Subcommittee

- June 27, 2012—Hearing on How Welfare and Tax Benefits Can Discourage Work.

Oversight Subcommittee

- March 2, 2011—Hearing on Improving Efforts to Combat Health Care Fraud.
- April 25, 2012—Hearing on the Impact of Limitations on the Use of Tax-Advantaged Accounts for the Purchase of Over-the-Counter Medication.
- September 11, 2012—Hearing on Internal Revenue Service's Implementation and Administration of The Democrats Health Care Law.
- March 5, 2013—Hearing on Tax-Related Provisions in the President's Health Care Law.
- June 10, 2014—Verification of Income and Insurance Information Under the Affordable Care Act.
- July 23, 2014—Hearing on the Integrity of the Affordable Care Act's Premium Tax Credit.
- May 20, 2015—Hearing on the Use of Administrative Action in the ACA Implementation.
- June 24, 2015—Hearing on Rising Health Insurance Premiums Under Obamacare.
- July 12, 2016—Hearing on Rising Health Insurance Premiums Under the Affordable Care Act.

II. EXPLANATION OF PROVISIONS

A. MODIFICATIONS AND REPEAL OF PREMIUM TAX CREDIT (SECS. 01– 03 OF THE COMMITTEE PRINT AND SEC. 36B OF THE CODE)

PRESENT LAW

In general

A refundable tax credit (the “premium assistance credit”) is provided for eligible individuals and families to subsidize the purchase of health insurance plans through an American Health Benefit Exchange (“Exchange”), referred to as “qualified health plans.”³ In general, advance payments with respect to the premium assistance credit are made during the year directly to the insurer, as discussed below. However, eligible individuals may choose to pay their total health insurance premiums without advance payments and claim the credit at the end of the taxable year.

Qualified health plans generally must meet certain requirements.⁴ Special rules apply to certain qualified health plans, referred to as “catastrophic-only” qualified health plans, which are available only to individuals who are under age 30 or meet other specified requirements.⁵ The premium assistance credit is not available with respect to catastrophic-only qualified health plans.⁶ In addition, in the case of a qualified health plan that provides coverage for abortions for which Federal funds may not be used, no part of the premium assistance credit may be used for the portion of premiums attributable to that coverage.⁷

The premium assistance credit is generally available for individuals (single or joint filers) with household incomes between 100 and 400 percent of the Federal poverty level (“FPL”) for the family size involved.⁸ Household income is defined as the sum of: (1) the individual’s modified adjusted gross income, plus (2) the aggregate modified adjusted gross incomes of all other individuals taken into account in determining the individual’s family size (but only if the other individuals are required to file a tax return for the taxable year). Modified adjusted gross income is defined as adjusted gross income increased by: (1) any amount excluded from gross income for citizens or residents living abroad,⁹ (2) any tax-exempt interest received or accrued during the tax year, and (3) the portion of the

³Under PPACA, an American Health Benefit Exchange is a source through which individuals can purchase health insurance coverage.

⁴Secs. 1301 and 1302 of PPACA.

⁵Sec. 1302(e) of PPACA.

⁶Under the Public Health Service Act (“PHSA”) as amended by the ACA, health insurance must meet certain requirements. Section 1251 of PPACA excepts certain health plans sold at the time of enactment of PPACA from some of the PHSA requirements (referred to as “grandfathered” plans). In addition, under guidance provided by the Center for Consumer Information & Insurance Oversight (“CCIIO,” part of the Department of Health and Human Services), including a letter dated November 14, 2013, to the State Insurance Commissioners and subsequent extensions, certain health plans that were sold in the individual insurance market as of January 1, 2013, are permitted to be sold after January 1, 2014, despite not complying with ACA requirements (referred to as “grandmothered plans”). The premium assistance credit is not available with respect to a grandfathered plan or a grandmothered plan.

⁷Sec. 1303(b)(2) of PPACA.

⁸Federal poverty level refers to the most recently published poverty guidelines determined by the Secretary of Health and Human Services (“HHS”). Levels for 2017 and previous years are available at <https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references>.

⁹Sec. 911.

individual's social security benefits not included in gross income.¹⁰ To be eligible for the premium assistance credit, individuals who are married must file a joint return. Individuals who are listed as dependents on a return are not eligible for the premium assistance credit.

An individual who is eligible for minimum essential coverage from a source other than the individual insurance market generally is not eligible for the premium assistance credit.¹¹ However, an individual who is offered minimum essential coverage under an employer-sponsored health plan may be eligible for the premium assistance credit if an employee's share of the premium for self-only coverage exceeds 9.69 percent (for 2017) of the employee's household income, or the plan's share of total allowed costs of benefits provided under the plan is less than 60 percent of such costs (called "minimum value"), and the individual declines the employer-offered coverage. An individual who enrolls in an employer-sponsored health plan generally is ineligible for the premium assistance credit, even if the coverage is considered unaffordable or does not provide minimum value.

As part of the process of enrollment in a qualified health plan through an Exchange, an individual may apply and be approved for advance payments with respect to a premium assistance credit ("advance payments").¹² The individual must provide information on income, family size, changes in marital or family status or income, and citizenship or lawful presence status.¹³ Eligibility for advance payments is generally based on the individual's income for the tax year ending two years prior to the enrollment period. The Exchange process includes a system through which information provided by the individual is verified using information from the Internal Revenue Service ("IRS") and certain other sources.¹⁴ If an individual is approved for advance payments, the Treasury pays the advance amount directly to the issuer of the health plan in which the individual is enrolled. The individual then pays to the issuer of the plan the difference between the advance payment amount and the total premium charged for the plan.

¹⁰ Under section 86, only a portion of an individual's social security benefits are included in gross income.

¹¹ Minimum essential coverage is defined in section 5000A(f).

¹² Secs. 1411–1412 of PPACA. Under section 1402 of PPACA, certain individuals eligible for advance premium assistance payments are eligible also for a reduction in their share of medical costs, such as deductibles and copays, under the plan, referred to as reduced cost-sharing. Eligibility for reduced cost-sharing is also determined as part of the Exchange enrollment process. The Department of Health and Human Services ("HHS") is responsible for rules relating to Exchanges and the eligibility determination process.

¹³ Under section 1312(f)(3) of PPACA, an individual may not enroll in a qualified health plan through an Exchange if the individual is not a citizen or national of United States or an alien lawfully present in the United States. Thus, such an individual is not eligible for the premium assistance credit.

¹⁴ Under section 6103, returns and return information are confidential and may not be disclosed, except as authorized by the Code, by the IRS, other Federal employees, State employees, and certain others having access to such information. Under section 6103(l)(21), upon written request of the Secretary of HHS, the IRS is permitted to disclose certain return information for use in determining an individual's eligibility for advance premium assistance payments, reduced cost-sharing, or certain other State health subsidy programs, including a State Medicaid program under title XIX of the Social Security Act, a State's Children's Health Insurance Program under title XXI of the Social Security Act and a Basic Health Program under section 1331 of PPACA.

Amount of credit

The premium assistance credit amount is generally the lower of (1) the premium for the qualified health plan in which the individual or family enrolls and (2) the premium for the second lowest cost silver plan in the rating area where the individual resides, reduced by the individual's or family's share of premiums.¹⁵ As shown in Table 1 below, an individual's or family's share of premiums is a certain percentage of household income. For 2017, the percentage is 2.04 percent for household income up to 133 percent of FPL and is determined on a sliding scale in a linear manner up to 9.69 percent as household income rises from 133 percent of FPL to 400 percent of FPL.

TABLE 1.—INDIVIDUAL'S SHARE OF PREMIUMS

(For 2017)¹⁶

Household income (expressed as a percent of FPL)	Initial percentage of household income	Final percentage of household income
100% up to 133%	2.04	2.04
133% up to 150%	3.06	4.08
150% up to 200%	4.08	6.43
200% up to 250%	6.43	8.21
250% up to 300%	8.21	9.69
300% up to 400%	9.69	9.69

Reconciliation of advance payment on return

An individual on whose behalf advance payments of the premium assistance credit for a taxable year are made is required to file an income tax return to reconcile the advance payments with the credit to which the individual is entitled for the taxable year.¹⁷

If the advance payments of the premium assistance credit exceed the amount of credit to which the individual is entitled, the excess ("excess advance payments") is treated as an additional tax liability on the individual's income tax return for the taxable year (referred to as "recapture"), subject to a limit on the amount of additional liability in some cases. For an individual with household income below 400 percent of FPL, liability for the excess advance payments for a taxable year is limited to a specific dollar amount (the "applicable dollar amount") as shown in Table 2 below. One-half of the applicable dollar amount shown in Table 2 applies to an unmarried

¹⁵The premium assistance amount is determined on a monthly basis and the credit for a year is the sum of the monthly amounts.

¹⁶Rev. Proc. 2016-24, 2016-18 I.R.B. 677. The percentages are indexed to the excess of premium growth over income growth for the preceding calendar year. After 2018, if the aggregate amount of premium assistance credits (and cost-sharing reductions under section 1402 of PPACA) exceeds 0.504 percent of the gross domestic product for that year, the percentage of income is also adjusted to reflect the excess (if any) of premium growth over the rate of growth in the consumer price index for the preceding calendar year.

¹⁷Under section 6055, health insurance issuers are required to report to the IRS and to an individual the months during a year for which the individual was covered by minimum essential coverage issued by the insurer in the individual market. In addition, under section 36B(f)(3), an Exchange is required to report to the IRS and to an individual the months during a year for which the individual was covered by a qualified health plan purchased through the Exchange, the premiums paid by the individual, and, if applicable, advance premium assistance payments made on behalf of the individual.

individual who is not a surviving spouse or filing as a head of household.

TABLE 2.—RECONCILIATION LIMIT ON ADDITIONAL TAX LIABILITY

(For 2017)¹⁸

Household income (expressed as a percent of FPL)	Applicable dollar amount
Less than 200%	\$600
At least 200% but less than 300%	\$1,500
At least 300% but less than 400%	\$2,550

If the advance payments of the premium assistance credit for a taxable year are less than the amount of the credit to which the individual is entitled, the additional credit amount is also reflected on the individual's income tax return for the year.

REASONS FOR CHANGE

The premium assistance tax credit contains basic flaws and has contributed to the weakening of the individual insurance market and increased inefficiencies in that market. Specifically, limiting the credit to health coverage purchased through an Exchange has led to segmentation of individual insurance markets and limited health plan choices in many areas. Denying the credit for catastrophic coverage, which can be an affordable option for younger individuals, has discouraged younger and healthier individuals from participating in insurance markets. Furthermore, the limits on recapture of excess advance payments allow some individuals to keep funds to which they are not entitled, thereby increasing the cost of the credit and Federal deficits. The Committee considers repeal and replacement of the premium assistance tax credit to be a fundamental element of true health care reform. However, the Committee also recognizes that making immediate changes can be disruptive for individuals, insurers and health care providers. The Committee therefore wishes to remedy the flaws of the premium assistance credit while providing a smooth transition period.

EXPLANATION OF PROVISION

Overview

The provision makes several modifications to the premium assistance credit for a transition period and repeals the premium assistance credit at the end of the transition period.

Recapture of excess advance payments

The provision repeals the present-law provision under which, in the case of an individual with household income below 400 percent of FPL, the additional tax liability resulting from excess advance payments is limited to the applicable dollar amount. Thus, under

¹⁸ Rev. Proc. 2016-55, 2015-45 I.R.B. 707. The applicable dollar amounts are indexed to reflect cost-of-living increases, with the amount of any increase rounded down to the next lowest multiple of \$50.

the provision, the full amount of excess advance payments is treated as an additional tax liability for the individual.

Application of credit to additional coverage

Under the provision, the premium assistance credit is available with respect to catastrophic-only qualified health plans. In addition, the premium assistance credit is available with respect to health plans that otherwise meet the requirements relating to qualified health plans, except that they are not offered through an Exchange.¹⁹ Thus, an individual who purchases a qualified health plan in the individual market, but not through an Exchange, may be eligible for the premium assistance credit if the requirements for eligibility are otherwise met.²⁰

Ineligibility of qualified health plans covering abortion

Under the provision, the premium assistance credit is not available with respect to a qualified health plan that includes coverage for abortions, other than an abortion necessary to save the life of the mother or an abortion with respect to a pregnancy that is the result of an act of rape or incest.²¹ For this purpose, the treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion is not considered an abortion.

Changes to individual share of premiums

The provision revises the schedule under which an individual's or family's share of premiums is determined in applying the credit for taxable years beginning 2019. As revised, the schedule varies with household income and with the age of the individual or family members, as shown in Table 3 below, subject to adjustment as described below.²² Initial and final percentages refer to percentage of the taxpayer's household income.

TABLE 3—INDIVIDUAL'S SHARE OF PREMIUMS

Household income (expressed as a percent of FPL)	Up to Age 29		Age 30–39		Age 40–49		Age 50–59		Over Age 59	
	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %
Up to 133%	2	2	2	2	2	2	2	2	2	2

¹⁹ As under present law, the credit is not available with respect to a grandfathered plan or grandmothered plan. In addition, as under present law, an individual who is not a citizen or national of the United States, or an alien lawfully present in the United States, is not eligible for the premium assistance credit.

²⁰ Advance premium assistance payments are not available with respect to a qualified health plan that is not purchased through an Exchange. An individual who purchases such a plan must claim the premium assistance credit on his or her income tax return. The provision amends the present-law reporting requirements under section 6055 so that additional information related to eligibility for the premium assistance credit is reported.

²¹ Nothing in the provision is to be construed as prohibiting any individual from purchasing separate coverage for abortions, or a health plan that includes those abortions, so long as no premium assistance credit is allowed with respect to the premiums for the coverage or plan. In addition, nothing in the provision restricts any health insurance issuer from offering separate coverage for abortions, or a plan that includes abortions, so long as premiums for the separate coverage or plan are not paid for with any amount attributable to the premium assistance credit (or the amount of any advance payment of the credit under section 1412 of PPACA).

²² For purposes of the schedule, an individual's age for a taxable year is the age the individual attains before the close of the taxable year, and, in the case of a joint return, the age of the older spouse is taken into account. As under present law, the applicable percentage is determined on a sliding scale in a linear manner as household income rises from 133 percent of FPL to 400 percent of FPL.

TABLE 3—INDIVIDUAL'S SHARE OF PREMIUMS—Continued

Household income (expressed as a percent of FPL)	Up to Age 29		Age 30–39		Age 40–49		Age 50–59		Over Age 59	
	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %
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	10.0
250%–300%	4.3	4.3	5.9	5.9	8.05	8.35	9	10.5	10	11.5
300%–400%	4.3	4.3	5.9	5.9	8.35	8.35	10.5	10.5	11.5	11.5

To determine the percentages applicable for taxable years beginning in calendar year 2019, the initial and final percentages may be subject to two adjustments. The first adjustment reflects the excess, if any, of (1) the rate of premium growth for the period beginning with calendar year 2013 and ending with calendar year 2018 over (2) the rate of income growth for that period. The second adjustment reflects the excess, if any, of (1) the rate of premium growth for calendar year 2018 over (2) the rate of growth in the consumer price index for calendar year 2018. However, the second adjustment applies only if the aggregate amount of premium assistance credits and cost-sharing reductions for calendar year 2018 exceeds 0.504 percent of the gross domestic product for that year.

Repeal of premium assistance credit

The provision terminates the premium assistance credit with respect to any coverage month beginning after December 31, 2019.²³

EFFECTIVE DATE

Repeal of the limit on additional tax liability resulting from excess advance payments is effective for taxable years beginning after December 31, 2017, and before January 1, 2020. The other transition modifications to the premium assistance credit are generally effective for taxable years beginning after December 31, 2017, except that the new schedule for determining an individual's or family's share of premiums is effective for taxable years beginning after December 31, 2018.²⁴ Repeal of the premium assistance credit is effective for months beginning after December 31, 2019, in taxable years ending after that date.²⁵

B. SMALL BUSINESS TAX CREDIT (SEC. 44 OF THE COMMITTEE PRINT AND SEC. 45R OF THE CODE)

PRESENT LAW

In general

Present law provides a tax credit for an eligible small employer for up to 50 percent of the employer's nonelective contributions to purchase health insurance for its employees. An eligible small em-

²³ The provision generally also repeals the provisions of sections 1411 and 1412 of PPACA relating to the determination of eligibility for advance premium assistance payments.

²⁴ The provision specifying that advance premium assistance payments are not available with respect to a qualified health plan that is not purchased through an Exchange is effective on January 1, 2018. The provision amending the present-law reporting requirements under section 6055 is effective for coverage provided for months beginning after December 31, 2017.

²⁵ Repeal of the provisions of sections 1411 and 1412 of PPACA relating to the determination of eligibility for advance premium assistance payments is effective January 1, 2020.

ployer for this purpose generally is an employer with no more than 25 full-time equivalent employees (“FTEs”) during the employer’s taxable year, whose average annual wages (for 2017) do not exceed \$52,400.²⁶ The full amount of the credit is available only to an employer with 10 or fewer FTEs whose average annual wages do not exceed (for 2017) \$26,200 and is phased out based on the number of FTEs over 10 and average annual wages over \$26,200.

For purposes of the credit, the employer is determined by applying the aggregation rules for controlled groups, groups under common control, and affiliated service groups.²⁷ In addition, for purposes of the credit, the term “employee” includes a leased employee, that is, an individual who is not an employee of the employer, who provides services to the employer pursuant to an agreement between the employer and another person (a “leasing organization”) and under the primary direction or control of the employer, and who has performed such services on a substantially full-time basis for at least one year.²⁸

Self-employed individuals (including partners and sole proprietors),²⁹ two-percent shareholders of an S Corporation,³⁰ and five-percent owners of the employer³¹ are not employees for purposes of the credit with the result that they are disregarded in determining number of FTEs, average annual wages, and nonelective contributions for employees’ health insurance. Family members of these individuals and any member of the individual’s household who is a dependent for tax purposes are also not employees for purposes of the credit. In addition, the hours of service worked by and wages paid to a seasonal worker of an employer are not taken into account in determining number of FTEs and average annual wages unless the worker works for the employer on more than 120 days during the taxable year.

The employer contributions must be provided under an arrangement that requires the eligible small employer to make, on behalf of each employee who enrolls in qualifying health insurance offered by the employer, a nonelective contribution equal to a uniform percentage (not less than 50 percent) of the premium cost of the qualifying health insurance.³² The credit is available only for nonelective contributions for premiums for insurance purchased through a Small Business Health Options (“SHOP”) Exchange and is available for a maximum credit period of two consecutive taxable years beginning with the first taxable year in which the employer (or any

²⁶ Wages for this purpose is defined as under the Federal Insurance Contributions Act (“FICA”), sections 3101–3128, without regard to the dollar limit on FICA wages under section 3121(a). The wage amounts relevant for purposes of the credit are indexed to the Consumer Price Index for Urban Consumers (“CPI-U”) for years beginning after 2013.

²⁷ Section 414(b) provides that, for specified employee benefit purposes, employees of corporations that are members of a controlled group of corporations are treated as employed by a single employer. Similarly, employees of trades or businesses (whether or not incorporated) under common control as provided in regulations under section 414(c), and employees of members of an affiliated service group as defined under section 414(m), are treated as employed by a single employer for specified employee benefit purposes. Section 414(o) authorizes the Secretary of the Treasury to issue regulations to prevent avoidance of the purposes specified in section 414(m).

²⁸ Sec. 414(n)(2).

²⁹ Sec. 401(c).

³⁰ Sec. 1372(b).

³¹ Five-percent owner is defined as for purposes of the qualified retirement plan top-heavy rules under section 416(i)(1)(B)(i).

³² A nonelective contribution is an employer contribution other than an employer contribution pursuant to a salary reduction arrangement.

predecessor) offers coverage to its employees through a SHOP Exchange.³³

The credit is available only to offset actual tax liability (that is, it is not a refundable credit) and is claimed on the employer's tax return. The credit is a general business credit and generally can be carried back for one year and carried forward for 20 years. The credit is available for tax liability under the alternative minimum tax. The dollar amount of the credit reduces the amount of employer contributions the employer may deduct as a business expense.

Tax-exempt organizations

A tax-exempt organization³⁴ that otherwise qualifies as an eligible small employer is eligible to receive the credit. For tax-exempt organizations, the applicable credit percentage is limited to 35 percent. In addition, for tax-exempt organizations, instead of being a general business credit, the credit is a refundable credit limited to the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins. For this purpose, "payroll taxes" means: (1) the amount of income tax required to be withheld from its employees' wages; (2) the amount of hospital insurance tax required to be withheld from its employees' wages; and (3) the amount of the hospital insurance tax imposed on the employer.³⁵

REASONS FOR CHANGE

The tax credit for health insurance premiums paid by an employer was intended to encourage small businesses to provide coverage to employees. However, the design of the credit limits its usefulness to these employers. The Committee believes that other measures to lower the cost of health coverage will provide more effective incentive for small employers. The Committee therefore wishes to repeal a credit in conjunction with providing such other measures.

EXPLANATION OF PROVISION

Ineligibility of qualified health plans covering abortion

Under the provision, the small employer health insurance credit is not available with respect to a qualified health plan that includes coverage for abortions, other than an abortion necessary to save the life of the mother or an abortion with respect to a pregnancy that is the result of an act of rape or incest.³⁶ For this purpose, the treatment of any infection, injury, disease, or disorder

³³The maximum two-year credit period does not take into account any taxable years beginning before 2014.

³⁴A tax-exempt organization is an organization described in section 501(c) that is exempt from tax under section 501(a).

³⁵Secs. 3402, 3101(b) and 3102, 3111(b).

³⁶Nothing in the provision is to be construed as prohibiting an employer from purchasing for its employees separate coverage for abortions, or a health plan that includes abortions, so long as no small employer health insurance credit is allowed with respect to the employer contributions for the coverage or plan. In addition, nothing in the provision restricts any health insurance issuer from offering separate coverage for abortions, or a plan that includes abortions, so long as the separate coverage or plan is not paid for with any employer contribution eligible for the credit.

that has been caused by or exacerbated by the performance of an abortion is not considered an abortion.

Repeal of the credit

The provision repeals the small employer health insurance credit.

EFFECTIVE DATE

The provision disallowing the credit with respect to a qualified health plan that provides coverage with respect to abortions is effective for taxable years beginning after December 31, 2017. The provision repealing the small employer health insurance credit is effective for taxable years beginning after December 31, 2019.

C. REPEAL OF INDIVIDUAL MANDATE PENALTY (SEC. 505 OF THE COMMITTEE PRINT AND SEC. 5000A OF THE CODE)

PRESENT LAW

Individuals must be covered by a health plan that provides at least minimum essential coverage or be subject to a tax (also referred to as a penalty) for failure to maintain the coverage (commonly referred to as the “individual mandate”).³⁷ Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, plans in the individual market, grandfathered group health plans and grandfathered health insurance coverage, and other coverage as recognized by the Secretary of Health and Human Services (“HHS”) in coordination with the Secretary of the Treasury.³⁸ The tax is imposed for any month that an individual does not have minimum essential coverage unless the individual qualifies for an exemption for the month as described below.

The tax for any calendar month is one-twelfth of the tax calculated as an annual amount. The annual amount is equal to the greater of a flat dollar amount or an excess income amount. The flat dollar amount is the lesser of (1) the sum of the individual annual dollar amounts for the members of the taxpayer’s family and (2) 300 percent of the adult individual dollar amount. The individual adult annual dollar amount is \$695 for 2017.³⁹ For an individual who has not attained age 18, the individual annual dollar amount is one half of the adult amount. The excess income amount is 2.5 percent of the excess of the taxpayer’s household income for the taxable year over the threshold amount of income for requiring the taxpayer to file an income tax return.⁴⁰ The total annual household payment may not exceed the national average annual premium for bronze level health plans for the applicable family size offered through Exchanges that year.

³⁷ If an individual is a dependent, as defined in section 152, of another taxpayer, the other taxpayer is liable for any tax for failure to maintain the required coverage with respect to the individual.

³⁸ Minimum essential coverage does not include coverage that consists of only certain excepted benefits, such as limited scope dental and vision benefits or long-term care insurance offered under a separate policy, certificate or contract.

³⁹ For years after 2016, the \$695 amount is indexed to CPI-U, rounded to the next lowest multiple of \$50.

⁴⁰ Sec. 6012(a).

Exemptions from the requirement to maintain minimum essential coverage are provided for the following: (1) an individual for whom coverage is unaffordable because the required contribution exceeds eight percent of household income, (2) an individual with household income below the income tax return filing threshold, (3) a member of an Indian tribe, (4) a member of certain recognized religious sects or a health sharing ministry, (5) an individual with a coverage gap for a continuous period of less than three months, and (6) an individual who is determined by the Secretary of HHS to have suffered a hardship with respect to the capability to obtain coverage.⁴¹

REASONS FOR CHANGE

The excise tax for failure to maintain a specific type of health coverage overrides personal health care choices, interferes in health care markets, and imposes an undue financial burden on families that fail to comply. The Committee believes that individuals should not be required to purchase specific Federally designed and dictated types of health insurance coverage to pay for medical care services.

EXPLANATION OF PROVISION

Under the provision, the amount of the tax for failure to maintain minimum essential coverage is zero. Thus, the provision effectively repeals the individual mandate.

EFFECTIVE DATE

The provision is effective for months beginning after December 31, 2015.

D. REPEAL OF EMPLOYER MANDATE PENALTY (SEC. __06 OF THE COMMITTEE PRINT AND SEC. 4980H OF THE CODE)

PRESENT LAW

In general

An applicable large employer, as defined below, may be subject to a tax, called an “assessable payment,” for a month if one or more of its full-time employees is certified to the employer as receiving for the month a premium assistance credit with respect to health insurance purchased through an Exchange (commonly referred to as the “employer mandate”).⁴² As discussed below, the amount of the assessable payment depends on whether the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under a group health plan sponsored by the employer and, if it does, whether the coverage offered is affordable and provides minimum value.

⁴¹ In addition, certain individuals present or residing outside of the United States and bona fide residents of United States territories are deemed to maintain minimum essential coverage.

⁴² As discussed in Part A, premium assistance credits under section 36B apply with respect to health insurance purchased through an Exchange. An employer may also be subject to an assessable payment if an employee received reduced cost sharing with respect to coverage purchased through an Exchange as discussed in Part A.

Definitions of full-time employee and applicable large employer

Applicable large employer generally means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year. For purposes of these rules, full-time employee means, with respect to any month, an employee who is employed on average at least 30 hours of service per week. Solely for purposes of determining whether an employer is an applicable large employer (that is, whether the employer has at least 50 full-time employees), besides the number of full-time employees, the employer must include the number of its full-time equivalent employees for a month, determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120. In addition, in determining whether an employer is an applicable large employer, members of the same controlled group, group under common control, and affiliated service group are treated as a single employer.⁴³ If the group is an applicable large employer under this test, each member of the group is an applicable large employer even if any member by itself would not be an applicable large employer.

Assessable payments

If an applicable large employer does not offer its full-time employees and their dependents minimum essential coverage under an employer-sponsored plan and at least one full-time employee is so certified to the employer, the employer may be subject to an assessable payment (for 2017) of \$2,260 (divided by 12 and applied on a monthly basis) multiplied by the number of its full-time employees in excess of 30, regardless of the number of full-time employees so certified.

Generally an employee who is offered minimum essential coverage under an employer-sponsored plan is not eligible for a premium assistance credit or reduced cost-sharing unless the coverage is unaffordable or fails to provide minimum value.⁴⁴ However, if an employer offers its full-time employees and their dependents minimum essential coverage under an employer-sponsored plan and at least one full-time employee is certified as receiving a premium assistance credit or reduced cost-sharing (because the coverage is unaffordable or fails to provide minimum value), the employer may be subject to an assessable payment (for 2017) of \$3,390 (divided by 12 and applied on a monthly basis) multiplied by the number of such full-time employees. However, the assessable payment in this case is capped at the amount that would apply if the employer failed to offer its full-time employees and their dependents minimum essential coverage.

⁴³The rules for determining controlled group, group under common control, and affiliated service group under section 414(b), (c), (m) and (o) apply for this purpose.

⁴⁴Coverage under an employer-sponsored plan is unaffordable if the employee's share of the premium for self-only coverage exceeds 9.5 percent of household income, and the coverage fails to provide minimum value if the plan's share of total allowed cost of provided benefits is less than 60 percent of such costs.

REASONS FOR CHANGE

The excise tax imposed on employers whose employees receive premium assistance credits or cost-sharing reductions interferes with market-driven compensation arrangements, encourages employers to cut hours and employees, and stifles new job creation. The Committee believes that repealing the excise tax will remove an unnecessary impediment preventing job creation and lead to more jobs and increased economic growth.

EXPLANATION OF PROVISION

Under the provision, the amount of the assessable penalties under the employer mandate is zero. Thus, the provision effectively repeals the employer mandate.

EFFECTIVE DATE

The provision is effective for months beginning after December 31, 2015.

E. REPEAL OF TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS (SEC. ___07 OF THE COMMITTEE PRINT AND SEC. 4980I OF THE CODE)

PRESENT LAW

In general

Effective for taxable years beginning after December 31, 2019, an excise tax is imposed on the provider of applicable employer-sponsored health coverage (the “coverage provider”) if the aggregate cost of the coverage for an employee (including a former employee, surviving spouse, or any other primary insured individual) exceeds a threshold amount (referred to as “high cost health coverage”). The tax is 40 percent of the amount by which aggregate cost exceeds the threshold amount (the “excess benefit”).

The annual threshold amount for 2018 is \$10,200 for self-only coverage and \$27,500 for other coverage (such as family coverage), multiplied by a one-time health cost adjustment percentage.⁴⁵ This threshold is then adjusted annually by an age and gender adjusted excess premium amount.⁴⁶ The age and gender adjusted excess premium amount is the excess, if any, of (1) the premium cost of standard FEHBP coverage for the type of coverage provided to an individual if priced for the age and gender characteristics of all employees of the employer, over (2) the premium cost of standard FEHBP coverage if priced for the age and gender characteristics of the national workforce. For this purpose, standard FEHBP coverage means the per employee cost of Blue Cross/Blue Shield

⁴⁵ The health cost adjustment percentage is 100 percent plus the excess, if any, of (1) the percentage by which the cost of standard FEHBP coverage for 2018 (determined according to specified criteria) exceeds the cost of standard FEHBP coverage for 2010, over (2) 55 percent.

⁴⁶ The 2018 threshold amounts are increased by \$1,650 for self-only coverage or \$3,450 for other coverage in the case of certain retirees and participants in a plan covering employees in a high-risk profession or repair or installation of electrical or telecommunications lines. For years after 2018, the threshold amounts (after application of the health cost adjustment percentage), and the increases for certain retirees and participants in a plan covering employees in a high-risk profession or repair or installation of electrical or telecommunications lines, are indexed to the Consumer Price Index for Urban Consumers (“CPI-U”) (CPI-U increased by one percentage point for 2019 only), rounded to the nearest \$50.

standard benefit coverage under the Federal Employees Health Benefit Program.

The excise tax is determined on a monthly basis, by reference to the monthly aggregate cost of applicable employer-sponsored coverage for the month and 1/12 of the annual threshold amount.

Applicable employer-sponsored coverage and determination of cost

Subject to certain exceptions, applicable employer-sponsored coverage is coverage under any group health plan offered to an employee by an employer that is excludible from the employee's gross income or that would be excludible if it were employer-sponsored coverage.⁴⁷ Thus, applicable employer-sponsored coverage includes coverage for which an employee pays on an after-tax basis. Applicable employer-sponsored coverage includes coverage under any group health plan established and maintained primarily for its civilian employees by the Federal government or any Federal agency or instrumentality, or the government of any State or political subdivision thereof or any agency or instrumentality of a State or political subdivision.

Applicable employer-sponsored coverage includes both insured and self-insured health coverage, including coverage in the form of reimbursements under a health flexible spending account ("health FSA") or a health reimbursement arrangement and contributions to a health savings account ("HSA") or Archer medical savings account ("Archer MSA").⁴⁸ In the case of a self-employed individual, coverage is treated as applicable employer-sponsored coverage if the self-employed individual is allowed a deduction for all or any portion of the cost of coverage.⁴⁹

For purposes of the excise tax, the cost of applicable employer-sponsored coverage is generally determined under rules similar to the rules for determining the applicable premium for purposes of COBRA continuation coverage,⁵⁰ except that any portion of the cost of coverage attributable to the excise tax is not taken into account. Cost is determined separately for self-only coverage and other coverage. Special valuation rules apply to retiree coverage, certain health FSAs, and contributions to HSAs and Archer MSAs.

Calculation of excess benefit and imposition of excise tax

In determining the excess benefit with respect to an employee (*i.e.*, the amount by which the cost of applicable employer-sponsored coverage for the employee exceeds the threshold amount), the

⁴⁷ Section 106 provides an exclusion for employer-provided coverage.

⁴⁸ Some types of coverage are not included in applicable employer-sponsored coverage, such as long-term care coverage, separate insurance coverage substantially all the benefits of which are for treatment of the mouth (including any organ or structure within the mouth) or of the eye, and certain excepted benefits. Excepted benefits for this purpose include (whether through insurance or otherwise) coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; and other similar insurance coverage (as specified in regulations), under which benefits for medical care are secondary or incidental to other insurance benefits. Applicable employer-sponsored coverage does not include coverage only for a specified disease or illness or hospital indemnity or other fixed indemnity insurance if the cost of the coverage is not excludible from an employee's income or deductible by a self-employed individual.

⁴⁹ Section 162(l) allows a deduction to a self-employed individual for the cost of health insurance.

⁵⁰ Sec. 4980B(f)(4).

aggregate cost of all applicable employer-sponsored coverage of the employee is taken into account. The threshold amount for self-only coverage generally applies to an employee. The threshold amount for other coverage applies to an employee only if the employee and at least one other beneficiary are enrolled in coverage other than self-only coverage under a group health plan that provides minimum essential coverage and under which the benefits provided do not vary based on whether the covered individual is the employee or other beneficiary. For purposes of the threshold amount, any coverage provided under a multiemployer plan is treated as coverage other than self-only coverage.⁵¹

The excise tax is imposed on the coverage provider.⁵² In the case of insured coverage (*i.e.*, coverage under a policy, certificate, or contract issued by an insurance company), the health insurance issuer is liable for the excise tax. In the case of self-insured coverage, the person that administers the plan benefits (“plan administrator”) is generally liable for the excise tax. However, in the case of employer contributions to an HSA or an Archer MSA, the employer is liable for the excise tax.

The employer is generally responsible for calculating the amount of excess benefit allocable to each coverage provider and notifying each coverage provider (and the IRS) of the coverage provider’s allocable share. In the case of applicable employer-sponsored coverage under a multiemployer plan, the plan sponsor is responsible for the calculation and notification.⁵³

REASONS FOR CHANGE

Like many in the country, employers—and employees—are concerned about increasing health care costs and the increasing portion of compensation needed to provide health coverage. Accordingly, employers are taking measures to contain costs and exploring options for additional measures. Although intended to contain health care costs by discouraging use of high cost employer-sponsored health coverage, the excise tax on such coverage punishes employers for complying with requirements to offer minimum essential coverage and with ACA regulations, thereby driving up the cost of such coverage. The Committee believes that postponing the punitive excise tax on employer-provided coverage in the context of true health care reform will prevent job loss, will provide relief to employers and employees who are facing increased premium costs, and will lead to increased economic growth, while providing employers with time to identify and implement their own measures to contain costs.

⁵¹ As defined in section 414(f), a multiemployer plan is generally a plan to which more than one employer is required to contribute and that is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer.

⁵² The excise tax is allocated pro rata among the coverage providers, with each responsible for the excise tax on an amount equal to the total excess benefit multiplied by a fraction, the numerator of which is the cost of the applicable employer-sponsored coverage of that coverage provider and the denominator of which is the aggregate cost of all applicable employer-sponsored coverage of the employee.

⁵³ The employer or multiemployer plan sponsor may be liable for a penalty if the total excise tax due exceeds the tax on the excess benefit calculated and allocated among coverage providers by the employer or plan sponsor.

EXPLANATION OF PROVISION

Under the provision, the excise tax on high cost employer-sponsored health coverage will not apply for any taxable period beginning after December 31, 2019, and before January 1, 2025. Thus, the tax will apply only for taxable periods beginning after December 31, 2024.

EFFECTIVE DATE

The provision is effective upon enactment.

F. REPEAL OF TAX ON OVER-THE-COUNTER MEDICATIONS (SEC. 108 OF THE COMMITTEE PRINT AND SECS. 106, 220 AND 223 OF THE CODE)

PRESENT LAW

Exclusion for employer-provided health benefits

Employees may exclude from gross income the value of employer-provided health coverage under an accident or health plan.⁵⁴ In addition, any reimbursements under an employer-provided accident or health plan for medical care expenses for employees, their spouses, their dependents, and adult children under age 27 generally are excludible from gross income.⁵⁵

An employer may agree to reimburse expenses for medical care of its employees (and their spouses, dependents, and adult children under age 27), not covered by a health insurance plan, through a flexible spending arrangement (“FSA”) which allows reimbursement not in excess of a specified dollar amount, provided the amount is only available for reimbursement for medical care.⁵⁶ The amount available for reimbursement is either elected by an employee under a cafeteria plan (“health FSA”) or otherwise specified by the employer under a health reimbursement arrangement (“HRA”). Reimbursements under these arrangements are also excludible from gross income as reimbursements for medical care under an employer-provided accident or health plan.

Health savings accounts

An individual with a high deductible health plan (and no other health plan other than a plan that provides certain permitted insurance or permitted coverage) may establish a health savings account (“HSA”).⁵⁷ Subject to limits, contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excludible from income (and from wages for payroll tax purposes). Contributions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize deductions. Distributions from an HSA that are used for qualified medical expenses are excludible from gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income and generally are subject to an additional tax of 20 percent. Similar

⁵⁴ Sec. 106.

⁵⁵ Sec. 105(b).

⁵⁶ Sec. 106(c)(1).

⁵⁷ Sec. 223.

rules apply for another type of medical savings arrangement called an Archer medical savings account (“Archer MSA”).⁵⁸

Definition of medical care for excludible reimbursements

For purposes of the exclusion for reimbursements under employer-provided accident and health plans (including under health FSAs and HRAs), and for distributions from HSAs and Archer MSAs used for qualified medical expenses, the definition of medical care is generally the same as the definition that applies for the itemized deduction for the cost of medical care and includes prescription medicine or drugs and insulin.⁵⁹ However, the definition of medical care for purposes of the exclusion for reimbursements for medical care under employer-provided accident and health plans and for distributions from HSAs and Archer MSAs used for qualified medical expenses includes an over-the-counter medicine but only if prescribed by a physician.⁶⁰ Thus, under present law, excludible treatment under a health FSA or an HRA is available on reimbursements for the cost of over-the-counter medicine only if the medicine is prescribed by a physician, and distributions from an HSA or an Archer MSA used to purchase over-the-counter medicine are not a qualified medical expense unless the medicine is prescribed by a physician.

REASONS FOR CHANGE

The requirement to obtain a prescription for an over-the-counter medicine in order for the cost of the medicine to be paid on a tax-favored basis from a health FSA, HRA, HSA, or Archer MSA has left consumers with three undesirable options: (1) seek an unnecessary appointment with a doctor to obtain a prescription before purchasing the medicine; (2) purchase the medicine without reimbursement, thus increasing the after-tax cost to the consumer; or (3) forego the medicine and leave a condition untreated, which could then worsen and necessitate more expensive treatment. The Committee notes that all three options increase costs to the consumer and to the healthcare system. The Committee believes that an over-the-counter medicine should be a qualified medical expense under a health FSA, HRA, HSA, or Archer MSA, regardless of whether a prescription is obtained. The requirement to obtain a prescription should therefore be repealed.

EXPLANATION OF PROVISION

The provision changes the definition of qualified medical care for purposes of the exclusions for reimbursements for medical care under employer-provided accident and health plans (including health FSAs and HRAs) and for distributions from HSAs or Archer MSAs used for qualified medical expenses to include over-the-counter medicine that is not prescribed by a physician. Thus, for example, amounts paid from a health FSA or HRA, or funds distributed from an HSA or an Archer MSA, to reimburse a taxpayer for over-the-counter medicine, such as nonprescription aspirin, al-

⁵⁸ Sec. 220.

⁵⁹ Sec. 213(d). There are certain limitations on the general definition including a rule that cosmetic surgery or similar procedures are generally not medical care.

⁶⁰ The prescription requirement does not apply to insulin.

lergy medicine, antacids, or pain relievers, will be excluded from income in accordance with the general rules associated with those health-related savings and reimbursement vehicles.

EFFECTIVE DATE

The provision is effective (1) in the case of HSAs and MSAs, amounts paid with respect to taxable years beginning after December 31, 2017, and (2) in the case of health FSAs and HRAs, expenses incurred with respect to taxable years beginning after December 31, 2017.

G. REPEAL OF INCREASE IN TAX ON HEALTH SAVINGS ACCOUNTS (SEC. 109 OF THE COMMITTEE PRINT AND SECS. 220 AND 223 OF THE CODE)

PRESENT LAW

Subject to limits, an individual with a high deductible health plan generally may make deductible contributions to a health savings account (“HSA”) or an Archer MSA (or “medical savings account”), which is a tax-exempt trust or custodial account. Employer contributions to Archer MSAs and HSAs on behalf of employees are excluded from income and wages, including Archer MSA and HSA contributions made with salary reduction contributions through a cafeteria plan.⁶¹ Thus, contributions to an HSA or Archer MSA are made on a pretax basis.

Distributions from an HSA or Archer MSA that are used for qualified medical expenses are excludible from gross income. Distributions that are not used for qualified medical expenses are includible in income and are generally subject to an additional tax. Before 2011, the additional tax on HSA distributions not used for qualified medical expenses was 10 percent of the distributed amount, and the additional tax on Archer MSA distributions not used for qualified medical expenses was 15 percent of the distributed amount. Effective for distributions made after December 31, 2010, the additional tax on distributions from an HSA or an Archer MSA that are not used for qualified medical expenses is 20 percent of the distributed amount.

REASONS FOR CHANGE

HSAs and Archer MSAs enable individuals to save for and pay for medical expenses on a tax-favored basis. The additional taxes on distributions not used for medical expenses are designed to discourage the use of HSA and Archer MSA funds for other purposes. However, financial pressures may leave an individual with no choice but using such funds for other purposes. In that case, an additional tax of 20 percent unduly increases financial pressure and results in further depletion of HSA and Archer MSA assets. The Committee believes that the prior-law rates of the additional tax are more appropriate and should be restored.

⁶¹Sec. 106(b) and (d). Employer contributions are subject to the same limits as individual contributions and reduce the amount of contributions that the individual can make.

EXPLANATION OF PROVISION

Under the provision, the additional tax on HSA distributions not used for qualified medical expenses is 10 percent of the distributed amount, and the additional tax on Archer MSA distributions not used for qualified medical expenses is 15 percent of the distributed amount.

EFFECTIVE DATE

The provision is effective for distributions made after December 31, 2017.

H. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO FLEXIBLE SPENDING ACCOUNTS (SEC. __10 OF THE COMMITTEE PRINT AND SEC. 125 OF THE CODE)

PRESENT LAW

A health flexible spending arrangement (“health FSA”) is an arrangement under which medical care expenses of an employee (and family members, if applicable) that are not covered by insurance may be paid or reimbursed.⁶² The funds available to an employee through a health FSA generally consist of the employee’s salary reduction contributions under a cafeteria plan, meaning that employees are given the option to reduce their current cash compensation and instead have the amount made available for use in reimbursing the employee for his or her medical expenses.⁶³ In order for a health FSA to be a qualified benefit under a cafeteria plan, an employee’s salary reduction contributions cannot exceed a dollar limit (\$2,600 for 2017).⁶⁴

REASONS FOR CHANGE

Health FSAs provide workers with pretax funds to pay for medical expenses not covered by insurance. Salary reduction contributions in turn give a worker the flexibility to coordinate the funds available through the health FSA with the actual level of his or her uncovered expenses. As a practical matter, therefore, the effect of the limit falls most heavily on workers with large uncovered expenses. The Committee believes the limit should be repealed in order to provide tax relief for these workers.

EXPLANATION OF PROVISION

The provision repeals the limitation on health FSA salary reduction contributions.

EFFECTIVE DATE

The provision applies to taxable years beginning after December 31, 2017.

⁶² Sec. 106(c)(2).

⁶³ Health FSAs may also include funds provided by the employer (often called “flex credits”).

⁶⁴ Sec. 125(i). The dollar limit is indexed to CPI-U, with any increase that is not a multiple of \$50 rounded to the next lowest multiple of \$50.

I. REPEAL OF MEDICAL DEVICE EXCISE TAX (SEC. 11 OF THE
COMMITTEE PRINT AND SEC. 4191 OF THE CODE)

PRESENT LAW

Effective for sales after December 31, 2012, excluding sales during the period beginning on January 1, 2016 and ending on December 31, 2017, a tax equal to 2.3 percent of the sale price is imposed on the sale of any taxable medical device by the manufacturer, producer, or importer of such device.⁶⁵ A taxable medical device is any device, as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act,⁶⁶ intended for humans. Regulations further define a medical device as one that is listed by the Food and Drug Administration (“FDA”) under section 510(j) of the Federal Food, Drug, and Cosmetic Act and 21 C.F.R. Part 807, pursuant to FDA requirements.⁶⁷

The excise tax does not apply to eyeglasses, contact lenses, hearing aids, or any other medical device determined by the Secretary to be of a type that is generally purchased by the general public at retail for individual use (“retail exemption”). Regulations provide guidance on the types of devices that are exempt under the retail exemption. A device is exempt under these provisions if: (1) it is regularly available for purchase and use by individual consumers who are not medical professionals; and (2) the design of the device demonstrates that it is not primarily intended for use in a medical institution or office or by a medical professional.⁶⁸ Additionally, the regulations provide certain safe harbors for devices eligible for the retail exemption.⁶⁹

The medical device excise tax is generally subject to the rules applicable to other manufacturers excise taxes. These rules include certain general manufacturers excise tax exemptions including the exemption for sales for use by the purchaser for further manufacture (or for resale to a second purchaser in further manufacture) or for export (or for resale to a second purchaser for export).⁷⁰ If a medical device is sold free of tax for resale to a second purchaser for further manufacture or for export, the exemption does not apply unless, within the six-month period beginning on the date of sale by the manufacturer, the manufacturer receives proof that the

⁶⁵Section 4191(c) provides a moratorium under which the medical device excise tax does not apply to sales during the period beginning on January 1, 2016, and ending on December 31, 2017.

⁶⁶21 U.S.C. sec. 321. Section 201(h) defines device as “an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is (1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them, (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or (3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes.”

⁶⁷Treas. Reg. sec. 48.4191–2(a). The regulations also include as devices items that should have been listed as a device with the FDA as of the date the FDA notifies the manufacturer or importer that corrective action with respect to listing is required.

⁶⁸Treas. Reg. sec. 48.4191–2(b)(2).

⁶⁹Treas. Reg. sec. 48.4191–2(b)(2)(iii). The safe harbors include devices that are described as over-the-counter devices in relevant FDA classification headings as well as certain FDA device classifications listed in the regulations.

⁷⁰Sec. 4221(a). Other general manufacturers excise tax exemptions (*i.e.*, the exemption for sales to purchasers for use as supplies for vessels or aircraft, to a State or local government, to a nonprofit educational organization, or to a qualified blood collector organization) do not apply to the medical device excise tax.

medical device has been exported or resold for use in further manufacturing.⁷¹ In general, the exemption does not apply unless the manufacturer, the first purchaser, and the second purchaser are registered with the Secretary of the Treasury. Foreign purchasers of articles sold or resold for export are exempt from the registration requirement.

The lease of a medical device is generally considered to be a sale of such device.⁷² Special rules apply for the imposition of tax to each lease payment. The use of a medical device subject to tax by manufacturers, producers, or importers of such device, is treated as a sale for the purpose of imposition of excise taxes.⁷³

There are also rules for determining the price of a medical device on which the excise tax is imposed.⁷⁴ These rules provide for (1) the inclusion of containers, packaging, and certain transportation charges in the price, (2) determining a constructive sales price if a medical device is sold for less than the fair market price, and (3) determining the tax due in the case of partial payments or installment sales.

REASONS FOR CHANGE

The U.S. medical device industry is a leader in medical technology innovation. The industry is an important contributor to the nation's economy, employing hundreds of thousands of people and manufacturing devices both for the U.S. and foreign markets. The United States is a net exporter of medical devices. The Committee believes that the excise tax on medical devices adversely affects the industry. The Committee believes that repealing the tax will decrease the cost of healthcare, encourage medical innovation, and lead to more jobs in the industry.

EXPLANATION OF PROVISION

Under the provision, the medical device excise tax applies only to sales before January 1, 2016. Thus, the medical device excise tax will not resume for sales in calendar years beginning after December 31, 2017.

EFFECTIVE DATE

The provision is effective upon enactment.

J. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY (SEC. __12 OF THE COMMITTEE PRINT AND SEC. 139A OF THE CODE)

PRESENT LAW

Sponsors of qualified retiree prescription drug plans are eligible for subsidy payments from the Secretary of HHS with respect to a portion of each qualified covered retiree's gross covered prescription drug costs ("qualified retiree prescription drug plan subsidy").⁷⁵ A

⁷¹ Sec. 4221(b).

⁷² Sec. 4217(a).

⁷³ Sec. 4218.

⁷⁴ Sec. 4216.

⁷⁵ Sec. 1860D-22 of the Social Security Act (SSA), 42 U.S.C. sec. 1395w-132.

qualified retiree prescription drug plan is employment-based retiree health coverage that has an actuarial value at least as great as the Medicare Part D standard plan for the risk pool and that meets certain other disclosure and recordkeeping requirements. These qualified retiree prescription drug plan subsidies are excludible from the plan sponsor's gross income.

In general, no deduction is allowed under any provision of the Code for any expense or amount that would otherwise be allowable as a deduction if the expense or amount is allocable to a class or classes of exempt income.⁷⁶ Thus, expenses incurred with respect to the subsidies excluded from income would generally not be deductible. For years before 2013, the exclusion for the qualified retiree prescription drug plan subsidy included a provision under which the exclusion was not taken into account in determining deductions with respect to the retiree prescription drug costs for which subsidy payments were received, thus allowing a deduction for costs subsidized by HHS payments. The ACA eliminated that provision and, as a result, the amount otherwise allowable as a deduction for retiree prescription drug costs is reduced by the amount of excludable subsidy payments received.

REASONS FOR CHANGE

Prescription drug coverage under employer-sponsored retiree health plans helps limit Medicare costs. The HHS subsidy for a qualified retiree prescription drug plan, accompanied by tax-free treatment of the subsidy and a deduction for retiree drug expenses, provides employers with a strong incentive to continue providing these plans. The Committee wishes to restore that incentive by restoring the deduction.

EXPLANATION OF PROVISION

Under the provision, the exclusion for qualified retiree prescription drug plan subsidy payments is not taken into account in determining whether a deduction is allowed with respect to retiree prescription drug costs taken into account in determining the subsidy payments from HHS. Therefore, a taxpayer may claim a deduction for covered retiree prescription drug expenses notwithstanding that the taxpayer excludes from income qualified retiree prescription drug plan subsidies received from HHS with respect to the expenses.

EFFECTIVE DATE

The provision is effective for taxable years beginning after December 31, 2017.

K. REPEAL OF INCREASE IN INCOME THRESHOLD FOR MEDICAL EXPENSE DEDUCTION (SEC. __13 OF THE COMMITTEE PRINT AND SEC. 213 OF THE CODE)

PRESENT LAW

An individual may claim an itemized deduction for unreimbursed medical expenses, but only to the extent that the expenses exceed

⁷⁶Sec. 265(a) and Treas. Reg. sec. 1.265-1(a).

10 percent of adjusted gross income.⁷⁷ For taxable years beginning before January 1, 2017, for purposes of the regular tax (but not for purposes of the AMT), the 10-percent threshold is reduced to 7.5 percent in the case of an individual who has attained the age of 65 before the close of the taxable year.⁷⁸

REASONS FOR CHANGE

The Committee believes that the increase of the income threshold for the medical expense deduction from 7.5 percent to 10 percent imposed a tax burden on individuals with high health care costs. The Committee believes that the increase of the threshold should be repealed, lowering the threshold back to the pre-2013 level for all taxpayers.

EXPLANATION OF PROVISION

The provision extends for one year the present-law regular tax 7.5-percent threshold for taxpayers who have attained the age of 65 before the close of the taxable year.

The provision permanently lowers the adjusted gross income threshold from 10 percent to 7.5 percent for all taxpayers (regardless of age) for purposes of both the regular tax and the AMT.

EFFECTIVE DATE

The provision extending the regular tax 7.5-percent threshold for taxpayers who have attained the age of 65 before the close of the taxable year is effective for taxable years beginning after December 31, 2016.

The provision lowering the adjusted gross income threshold from 10 percent to 7.5 percent for all taxpayers is effective for taxable years beginning after December 31, 2017.

L. REPEAL OF MEDICARE TAX INCREASE (SEC. __ 14 OF THE COMMITTEE PRINT AND SECS. 1401 AND 3101 OF THE CODE)

PRESENT LAW

Social Security and Medicare taxes—in general

The Federal Insurance Contributions Act (“FICA”) imposes tax on employers and employees based on the amount of wages (as defined for FICA purposes) paid to an employee during the year.⁷⁹ The tax imposed on the employer and on the employee each consists of two parts: (1) the social security or old age, survivors, and disability insurance (“OASDI”) tax equal to 6.2 percent of covered wages up to the taxable wage base (\$127,200 for 2017); and (2) the Medicare or hospital insurance (“HI”) tax equal to 1.45 percent of all covered wages (including wages above the taxable wage base).⁸⁰ The combined employer and employee taxes result in a total OASDI tax rate of 12.4 percent of covered wages up to the taxable

⁷⁷ For taxable years beginning before January 1, 2013, the threshold was 7.5 percent for the regular tax and 10 percent for alternative minimum tax (“AMT”).

⁷⁸ In the case of married taxpayers, the 7.5 percent threshold applies if either spouse has obtained the age of 65 before the close of the taxable year.

⁷⁹ Secs. 3101–3128.

⁸⁰ Social security and Medicare taxes respectively fund the Social Security and Medicare trust funds.

wage base and a total Medicare tax rate of 2.9 percent of all covered wages. The employee portion of the FICA tax generally must be withheld and remitted to the Federal government by the employer. If the employer fails to withhold the employee portion, the employer is generally liable for the amount that should have been withheld.

Instead of FICA taxes, railroad employers and employees are subject, under the Railroad Retirement Tax Act ("RRTA"), to taxes equivalent to the OASDI and Medicare taxes under FICA with respect to compensation as defined for RRTA purposes ("RRTA compensation").⁸¹ The employee portion of RRTA taxes generally must be withheld from an employee's RRTA compensation and remitted to the Federal government by the employer.

As a parallel to FICA and RRTA taxes, the Self-Employment Contributions Act ("SECA") imposes tax on the self-employment income of self-employed individuals.⁸² The rate of the OASDI portion of SECA tax is equal to the combined employee and employer OASDI FICA tax rates (12.4 percent) and applies to self-employment income up to the FICA taxable wage base (reduced by FICA wages, if any). Similarly, the rate of the Medicare portion of SECA tax is the same as the combined employer and employee Medicare rates (2.9 percent) and applies to all self-employment income.

Additional Medicare tax

An additional Medicare tax of 0.9 percent is imposed on employees and self-employed individuals with FICA wages, RRTA compensation or self-employment income exceeding a threshold amount.

Under FICA and RRTA, the employee portion of the Medicare tax (not the employer portion) is increased by an additional tax of 0.9 percent on wages received in excess of the threshold amount. The threshold amount is \$250,000 in the case of a joint return, \$125,000 in the case of a married individual filing a separate return, and \$200,000 in any other case. Thus, in the case of a joint return, the additional Medicare tax is based on the combined wages of an employee and the employee's spouse.

An employer is required to withhold the additional Medicare tax from an employee's wages and RRTA compensation only to the extent wages or compensation paid to the employee by the employer exceeds \$200,000. The employer's withholding obligation does not depend on the amount of the employee's ultimate liability for the additional Medicare tax, if any. That is, the amount required to be withheld may be more or less than the employee's ultimate liability. If the employee's liability is more than the amount withheld, the employee must pay the additional amount. If the employee's liability is less than the amount withheld, the employee may claim a refund.

The additional Medicare tax applies also to self-employment income in excess of the threshold amount. As in the case of the additional Medicare tax for employees, the threshold amount for the additional SECA Medicare tax is \$250,000 in the case of a joint re-

⁸¹ Secs. 3201–3233.

⁸² Secs. 1401–1403.

turn, \$125,000 in the case of a married individual filing a separate return, and \$200,000 in any other case. The threshold amount is reduced (but not below zero) by the amount of wages taken into account in determining the individual's additional FICA Medicare tax, if any. Thus, only a single threshold amount applies for an individual (or individual and spouse) with both FICA wages and self-employment income.

REASONS FOR CHANGE

The Committee believes that taxes to fund Medicare should vary proportionately with wages, the result provided by the basic 2.9 percent combined Medicare tax rate under FICA and the basic Medicare tax rate under SECA. The additional 0.9 percent Medicare tax imposes a disproportionate tax burden on some taxpayers. Furthermore, the wage thresholds at which the additional tax applies are not indexed for inflation. Real wage growth will cause more and more taxpayers to become subject to the higher tax rates over time. Therefore, the Committee considers it appropriate to repeal the additional Medicare tax.

EXPLANATION OF PROVISION

The provision repeals the additional 0.9 percent Medicare tax.

EFFECTIVE DATE

The provision is effective with respect to remuneration received after, and taxable years beginning after, December 31, 2017.

M. REFUNDABLE TAX CREDIT FOR HEALTH INSURANCE COVERAGE
(SEC. 15 OF THE COMMITTEE PRINT AND NEW SECS. 36C, 7529, 7530, AND 6050X OF THE CODE)

PRESENT LAW

Premium assistance credit

In general

A refundable tax credit (the “premium assistance credit”) is provided for eligible individuals and families to subsidize the purchase of health insurance plans through an Exchange, referred to as “qualified health plans.”⁸³ The premium assistance credit is generally available for individuals (single or joint filers) with household incomes between 100 and 400 percent of the Federal poverty level (“FPL”) for the family size involved. An individual who is eligible for minimum essential coverage from a source other than the individual insurance market, such as employer-provided coverage,

⁸³ Sec. 36B. Under the Public Health Service Act (“PHSA”) as amended by the ACA, health insurance must meet certain requirements. Section 1251 of PPACA excepts certain health plans sold at the time of enactment of PPACA from some of the PHSA requirements (referred to as “grandfathered” plans). In addition, under guidance provided by the Center for Consumer Information & Insurance Oversight (“CCHIO,” part of the Department of Health and Human Services), including a letter dated November 14, 2013, to the State Insurance Commissioners and subsequent extensions, certain health plans that were sold in the individual insurance market as of January 1, 2013, are permitted to be sold after January 1, 2014, despite not complying with ACA requirements (referred to as “grandmothered plans”). The premium assistance credit is not available with respect to a grandfathered plan or a grandmothered plan. Another provision in the bill repeals the premium assistance credit.

generally is not eligible for the premium assistance credit.⁸⁴ In general, advance payments with respect to the premium assistance credit are made during the year directly to the insurer, as discussed below. However, eligible individuals may choose to pay their total health insurance premiums without advance payments and claim the credit at the end of the taxable year.

As part of the process of enrollment in a qualified health plan through an Exchange, an individual may apply and be approved advance payments with respect to a premium assistance credit (“advance payments”).⁸⁵ The individual must provide information on income, family size, changes in marital or family status or income, and citizenship or lawful presence status.⁸⁶ Eligibility for advance payments is generally based on the individual’s income for the tax year ending two years prior to the enrollment period. The Exchange process includes a system through which information provided by the individual is verified using information from the IRS and certain other sources.⁸⁷ If an individual is approved for advance premium assistance payments, the Treasury pays the advance amount directly to the issuer of the health plan in which the individual is enrolled. The individual then pays to the issuer of the plan the difference between the advance payment amount and the total premium charged for the plan.

Amount of credit and reconciliation of advance payment on return

The premium assistance credit amount is generally the lower of (1) the premium for the qualified health plan in which the individual or family enrolls and (2) the premium for the second lowest cost silver plan in the rating area where the individual resides, reduced by the individual’s or family’s share of premiums, determined as a specified percentage of household income.⁸⁸ Household

⁸⁴ Minimum essential coverage is defined in section 5000A(f). An individual covered by a qualified small employer health reimbursement arrangement (“QSEHRA”) as defined in section 9831(d) may be eligible for the premium assistance credit. In that case, the amount of the credit is reduced by the benefit amount available to an individual under the QSEHRA. Under section 162(l), a self-employed individual may take a deduction in determining adjusted gross income (“AGI”), that is, an “above-the line” deduction, for the cost of health insurance for the individual and the individual’s spouse, dependents and, under the ACA, children up to age 26. Under section 213, an individual may take an itemized deduction for medical expenses, including health insurance premiums, that exceed 10 percent of AGI. If an individual receives a premium assistance credit, the amount of premiums taken into account in determining a deduction under section 162(l) or 213 is reduced by the amount of the credit.

⁸⁵ Secs. 1411–1412 of PPACA. Under section 1402 of PPACA, certain individuals eligible for advance premium assistance payments are eligible also for a reduction in their share of medical costs, such as deductibles and copays, under the plan, referred to as reduced cost-sharing. Eligibility for reduced cost-sharing is also determined as part of the Exchange enrollment process. The Department of Health and Human Services (“HHS”) is responsible for rules relating to Exchanges and the eligibility determination process.

⁸⁶ Under section 1312(f)(3) of PPACA, an individual may not enroll in a qualified health plan through an Exchange if the individual is not a citizen or national of the United States or an alien lawfully present in the United States. Thus, such an individual is not eligible for the premium assistance credit.

⁸⁷ Under section 6103, returns and return information are confidential and may not be disclosed, except as authorized by the Code, by the IRS, other Federal employees, State employees, and certain others having access to such information. Under section 6103(1)(21), upon written request of the Secretary of HHS, the IRS is permitted to disclose certain return information for use in determining an individual’s eligibility for advance premium assistance payments, reduced cost-sharing, or certain other State health subsidy programs, including a State Medicaid program under title XIX of the Social Security Act, a State’s Children’s Health Insurance Program under title XXI of the Social Security Act and a Basic Health Program under section 1331 of PPACA.

⁸⁸ The premium assistance amount is determined on a monthly basis and the credit for a year is the sum of the monthly amounts.

income is defined as the sum of: (1) the individual's modified adjusted gross income, plus (2) the aggregate modified adjusted gross incomes of all other individuals taken into account in determining the individual's family size (but only if the other individuals are required to file a tax return for the taxable year). Modified adjusted gross income is defined as adjusted gross income increased by: (1) any amount excluded from gross income for citizens or residents living abroad,⁸⁹ (2) any tax-exempt interest received or accrued during the tax year, and (3) the portion of the individual's social security benefits not included in gross income.⁹⁰

An individual on whose behalf advance payments of the premium assistance credit for a taxable year are made is required to file an income tax return to reconcile the advance payments with the credit to which the individual is entitled for the taxable year. If the advance payments of the premium assistance credit exceed the amount of credit to which the individual is entitled, the excess ("excess advance payments") is treated as an additional tax liability on the individual's income tax return for the taxable year (referred to as "recapture"), subject to a limit on the amount of additional liability in some cases. For an individual with household income below 400 percent of FPL, liability for the excess advance payments for a taxable year is limited to a specific dollar amount (the "applicable dollar amount") as shown in Table 4 below. One-half of the applicable dollar amount shown in Table 4 applies to an unmarried individual who is not a surviving spouse or filing as a head of household.

TABLE 4.—RECONCILIATION LIMIT ON ADDITIONAL TAX LIABILITY

(For 2017)⁹¹

Household income (expressed as a percent of FPL)	Applicable dollar amount
Less than 200%	\$600
At least 200% but less than 300%	\$1,500
At least 300% but less than 400%	\$2,550

If the advance payments of the premium assistance credit for a taxable year are less than the amount of the credit to which the individual is entitled, the additional credit amount is also reflected on the individual's income tax return for the year.

Health coverage tax credit

Another refundable tax credit (the "health coverage tax credit" or "HCTC") is available to certain individuals for months beginning before January 1, 2020, generally based on eligibility relating to the Trade Adjustment Assistance ("TAA") program or the receipt of

⁸⁹Sec. 911.

⁹⁰Under section 86, only a portion of an individual's social security benefits are included in gross income.

⁹¹Rev. Proc. 2016-55, 2015-45 I.R.B. 707. The applicable dollar amounts are indexed to reflect cost-of-living increases, with the amount of any increase rounded down to the next lowest multiple of \$50.

pension benefits from the Pension Benefit Guaranty Corporation.⁹² The credit amount is 72.5 percent of the individual's premiums for qualified health insurance of the individual and qualifying family members for each eligible coverage month beginning in the taxable year. The credit is available on an advance payment basis through a program established by the IRS.⁹³ In the case of an individual on whose behalf advance HCTC payments are made, the individual's income tax liability is increased by the amount of the advance payment, but then offset by the amount of the HCTC allowed to the individual.⁹⁴

Health Savings Accounts

An individual with a high deductible health plan and no other health plan (other than a plan that provides certain permitted insurance or permitted coverage) may establish a health savings account ("HSA").⁹⁵ Subject to limits, contributions to an HSA made by or on behalf of an eligible individual are deductible in determining adjusted gross income of the individual (that is, an "above-the-line" deduction). Contributions to an HSA by an employer for an employee (including salary reduction contributions made through a cafeteria plan) are excludible from income and from wages for employment tax purposes.⁹⁶ Distributions from an HSA for qualified medical expenses are not includible in gross income. An individual may roll funds over from one HSA to another on a nontaxable basis. In that case, the amount of the rollover is not taken into account in applying the HSA contribution limits.

Reporting relating to health insurance and employer-provided health coverage

A health insurance issuer is required to report to the IRS and to an individual the months during a year for which the individual was covered by minimum essential coverage issued by the insurer in the individual market.⁹⁷ In addition, an Exchange is required to report to the IRS and to an individual the months during a year for which the individual was covered by a qualified health plan purchased through the Exchange, the premiums paid by the individual, and, if applicable, advance premium assistance payments made on behalf of the individual.⁹⁸ An employer generally is required to report the cost of health coverage provided to an employee on Form W-2.⁹⁹

Penalty for claim of excess credit

Present law imposes a penalty of 20 percent on the amount by which a claim for refund or credit exceeds the amount allowable unless it is shown that the claim has reasonable cause.¹⁰⁰

⁹² Sec. 35.

⁹³ Sec. 7527.

⁹⁴ Rules to coordinate eligibility for the HCTC and the premium assistance credit apply in the case of an individual who is eligible for both.

⁹⁵ Sec. 223.

⁹⁶ Secs. 106(d), 125, 3121(a)(2), 3231(e)(1), 3306(b)(2), 3401(a)(22).

⁹⁷ Sec. 6055.

⁹⁸ Sec. 36B(f)(3).

⁹⁹ Sec. 6051(a)(14).

¹⁰⁰ Sec. 6676. This penalty does not apply to the portion of any claim to which accuracy-related and fraud penalties apply.

REASONS FOR CHANGE

The Committee recognizes that an advanceable tax credit will facilitate the purchase of health insurance by lower- and middle-income individuals. The Committee therefore wishes to provide such a credit. At the same time, the Committee wishes to avoid the flaws in the design of the present-law premium assistance credit, such as the limits on recapture of excess advance payments. In addition, because premiums are higher for older individuals, the Committee believes that credit amounts should increase with age. The Committee wishes also to provide an additional incentive for the purchase of high deductible health plans, which further the goal of containing health costs by encouraging consumers to be cost conscious in their use of health care, as reflected in lower premiums for such plans. The Committee believes an additional incentive can be provided by allowing an individual who purchases a high deductible health plan with premiums lower than the maximum credit to designate an HSA into which the difference will be deposited. Finally, the Committee wishes to limit the cost of the credit to the Federal budget by including a maximum credit amount, which varies by family size, and by phasing out the credit for higher-income individuals.

EXPLANATION OF PROVISION

In general

The provision establishes a refundable tax credit with respect to eligible health insurance for individuals and their qualifying family members for eligible coverage months. Qualifying family members are the individual's spouse in the case of a joint return, a dependent, and a child who has not attained age 27 as of the end of the taxable year and is covered for the month by the same health insurance plan as the individual or the individual's spouse.¹⁰¹

The total credit for a taxable year is the lesser of (1) the sum of the monthly credit amounts described below for the year, subject to reduction based on modified adjusted gross income, as described below, and (2) the amount paid for eligible health insurance for the individual and qualifying family members for eligible coverage months beginning during the year.¹⁰² Advance payments with respect to the credit may be made during the year directly to the insurer, as discussed below. Alternatively, individuals may choose to pay their total health insurance premiums without advance payments and claim the credit at the end of the taxable year.

¹⁰¹ In order to claim the credit, married individuals must file a joint return. A dependent, or a child described above, may not claim the credit with respect to the same period for which a credit is claimed by the individual. If a health insurance plan covers a person other than the individual and qualifying family members, rules similar to the rules of section 213(d)(6) apply in allocating the amount paid for the coverage.

¹⁰² Amounts paid for eligible health insurance may not be taken into account in determining a deduction under section 162(l) or 213 except to the extent they exceed the amount of the credit (plus the amount deposited into an HSA as described below, if applicable). In the case of an individual covered by a QSEHRA, the amount of the credit is reduced by the benefit amount available to an individual under the QSEHRA. The provision includes rules to coordinate eligibility for the HCTC and the new credit in the case of an individual who is eligible for both.

Definitions

Eligible coverage month

For purposes of the credit, a month is an eligible coverage month with respect to an individual if, as of the first day of the month, the individual—

- is covered by eligible health insurance,
- is not eligible for other specified coverage,
- is a citizen or national of the United States or a qualified alien,¹⁰³ and
- is not incarcerated, other than incarceration pending the disposition of charges.

Eligible health insurance

Eligible health insurance is health insurance coverage—¹⁰⁴

- that is offered in the individual market within a State or is unsubsidized COBRA continuation coverage,¹⁰⁵
- substantially all of which is not of excepted benefits,¹⁰⁶
- that does not include coverage relating to abortions, other than an abortion necessary to save the life of the mother or an abortion with respect to a pregnancy that is the result of an act of rape or incest,¹⁰⁷
- that does not consist of short-term limited duration insurance (as defined by the Secretary),¹⁰⁸ and
- with respect to which, the State in which the insurance is offered (or, in the case of unsubsidized COBRA continuation coverage under a group health plan, the plan administrator)

¹⁰³ Qualified alien is defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641).

¹⁰⁴ Health insurance coverage is defined in section 9832(b) and means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. Health insurance issuer means an insurance company, insurance service, or insurance organization (including a health maintenance organization) that is licensed to engage in the business of insurance in a State and which is subject to State law regulating. A group health plan, defined below, is not a health insurance issuer.

¹⁰⁵ Individual health insurance market means the market for health insurance coverage offered to individuals other than in connection with a group health plan, defined below. COBRA continuation coverage generally means continuation coverage provided under section 4980B, sections 601–608 of the Employee Retirement Income Security Act of 1974, or Title XXII of the PHS Act, temporary continuation coverage under the Federal Employees Health Benefit Program, or coverage under a State program that provides comparable continuation coverage. It does not include coverage under a health flexible spending arrangement. Unsubsidized COBRA continuation coverage means COBRA continuation coverage no portion of the premiums for which are subsidized by the employer.

¹⁰⁶ Excepted benefits is defined in section 9832(b). Excepted benefits are various types of arrangements providing only limited coverage, such as dental, vision or long-term care.

¹⁰⁷ For purposes of this restriction, the treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion is not considered an abortion. In addition, nothing in the provision is to be construed as prohibiting any individual from purchasing separate coverage for abortions, or a health plan that includes those abortions, so long as no credit under the provision is allowed with respect to the premiums for the coverage or plan. In addition, nothing in the provision restricts any health insurance issuer offering a health plan from offering separate coverage for abortions, or a plan that includes those abortions, so long as premiums for the separate coverage or plan are not paid for with any amount attributable to the credit under the provision.

¹⁰⁸ It is expected that the definition will be consistent with the definition used for purposes of the group health plan rules under Chapter 100 of the Code, currently in Treas. Reg. sec. 54.9801–2.

certifies that the coverage meets the preceding requirements.¹⁰⁹

Other specified coverage

Other specified coverage is (1) coverage under a group health plan,¹¹⁰ other than COBRA continuation coverage or coverage under a plan substantially all of the coverage of which is of excepted benefits, (2) Part A Medicare coverage, (3) Medicaid coverage, (4) coverage under the Children's Health Insurance Plan ("CHIP"), (5) military-related medical coverage, including coverage under the TRICARE program, (6) coverage under a veterans health care program, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary of the Treasury,¹¹¹ (7) coverage under a health plan for Peace Corps volunteers, or (8) coverage under the Non-appropriated Fund Health Benefits Program of the Department of Defense.

Credit amount

The monthly credit amount applicable with respect to an individual is 1/12 of an annual amount that varies with the age of the individual as follows:

Age of individual ¹	Under age 30	Has attained age 30 but under age 40	Has attained age 40 but under age 50	Has attained age 50 but under age 60	Has attained age 60 (and is not eligible for Medicare)
Annual credit amount	\$2,000	\$2,500	\$3,000	\$3,500	\$4,000

¹ Age for this purpose is determined as of the beginning of the taxable year.

In general, the monthly credit amount for a family is the sum of the monthly credit amounts applicable with respect to the five oldest family members with respect to whom monthly credit amounts are available. The maximum credit amount with respect to a family for a taxable year is \$14,000.¹¹² In addition, the credit amount otherwise determined for a taxable year under this rule is reduced (but not below zero) by 10 percent of the excess (if any) of (1) the individual's modified adjusted gross income for the taxable year, over (2) \$75,000 (twice this amount in the case of a joint return).¹¹³ For this purpose, modified adjusted gross income means adjusted gross income increased by: (1) any amount excluded from gross income for citizens or residents living abroad, (2) any tax-exempt interest received or accrued during the tax year, and (3) the portion

¹⁰⁹ A State certification will not be taken into account for this purpose unless the certification is made available to the public and meets such other requirements as the Secretary may provide. A certification relating to COBRA coverage must meet requirements provided by the Secretary.

¹¹⁰ Group health plan is defined in section 5000(b)(1) and means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. Group health plan includes a health plan maintained by a governmental employer, such as the Federal Employees Health Benefit Program.

¹¹¹ An individual is not treated as eligible for this coverage unless enrolled in the coverage.
¹¹² For years after 2020, the monthly and maximum credit amounts are increased to reflect increases in cost-of-living based on the consumer price index ("CPI") plus one percentage point, with the result rounded to the nearest multiple of \$50.

¹¹³ For years after 2020, the modified adjusted gross income amount is increased to reflect increases in cost-of-living based on the consumer price index ("CPI") plus one percentage point, with the result rounded to the nearest multiple of \$50.

of the individual's social security benefits not included in gross income.

The total credit for a taxable year cannot exceed the amount paid for eligible health insurance for the individual and qualifying family members eligible for coverage months beginning during the year. If the amount paid for the insurance is less than the maximum credit amount described above and the individual or a qualifying family member is eligible to contribute to a health savings account ("HSA") for the year, at the request of the individual, the Secretary may deposit the excess into the HSA (or among one or more HSAs) of the individual or a qualifying family member as designated by the individual.¹¹⁴ The deposit is generally treated as a rollover, and the amount deposited is not taken into account for purposes of the limits on HSA contributions.

Advance payments and reconciliation

The provision directs the Secretary, in consultation with the Secretary of HHS, the Secretary of Homeland Security, and the Commissioner of Social Security, to establish a program not later than January 1, 2020, for making payments to providers of eligible health insurance on behalf of individuals eligible for the credit (an "advance payment" program). The aggregate advance payments made with respect to any individual, determined as of any time during any calendar year, must not exceed the monthly credit amounts determined with respect to the individual under the provision for completed months during the year.

The program established for making advance payments is, to the greatest extent practicable, to use the methods and procedures used to administer the programs created under the rules relating to advance payments of the present-law premium assistance credit (as in effect before repeal by another provision), and each entity required to take any actions under those programs is, at the request of the Secretary, to take those actions to the extent necessary to carry out the advance payment program under the provision, including HHS. Except as otherwise provided by the Secretary, in making advance payments with respect to eligible health insurance that is not enrolled in through an Exchange, the rules relating to advance payments of the present-law premium assistance credit are to be applied by treating references to an Exchange as references to the provider of the eligible health insurance (or, as the Secretary determines appropriate, to the licensed agent or broker with respect to the insurance).¹¹⁵

The advance payment program is to provide that any individual applying to have payments made on their behalf under the program must, if the individual (or any qualifying family member taken into account in determining the amount of the credit) is employed, submit a written statement from each employer of the indi-

¹¹⁴ If the individual (or, in the case of a joint return, either spouse) has a seriously delinquent tax debt, as defined in section 7345(b), that has not been fully satisfied, the Secretary will not make any HSA deposit, and if the beneficiary of the designated HSA has a seriously delinquent tax debt, the Secretary will not make a deposit to that HSA.

¹¹⁵ As under present law, the provision includes authority for the IRS to disclose a limited amount of return information for purposes of determining eligibility for the new credit and certain State health subsidy programs. In addition, for insurance not purchased from an Exchange, the provision permits the disclosure to the provider of the insurance, the amount of any advance payment for which the taxpayer may be eligible.

vidual or qualifying family member stating whether the individual or qualifying family member (as the case may be) is eligible for other specified coverage in connection with the employment. An employer must, at the request of any employee, provide such a statement at the time, and in the form and manner, as the Secretary may provide.¹¹⁶

If an individual receives advance payments under the provision for a taxable year, the credit amount for which the individual would otherwise be eligible is reduced (but not below zero) by the aggregate amount of the advance payments for months beginning in the taxable year. If the aggregate amount of the individual's advance payments for months beginning in the taxable year exceed the credit amount for which the individual is eligible (before the previously described reduction), the individual's tax liability for the year is increased by the excess.

Reporting

Provider of eligible health insurance

Under the provision, any person who provides eligible health insurance for any month of any calendar year with respect to any individual is required to report certain information to the IRS, generally at the time prescribed by the Secretary. However, in the case of an individual with respect to whom payments are made under the advance payment program, the reports to the IRS must be made on a monthly basis. The required reporting is to be in the form prescribed by the Secretary and must include the following information with respect to each policy of eligible health insurance:

- the name, address, and tax identification number of each individual covered under the policy,
- the premiums paid with respect to the policy,
- the amount of advance payments made on behalf of the individual,
- the months during which the health insurance is provided to the individual,
- whether the policy constitutes a high deductible health plan, and
- any other information prescribed by the Secretary.

The same information must be provided to the individual, on or before January 31 of the year following the calendar year to which it relates, and must also include the name and address of the person required to report and the phone number of the information contact for that person.

Employer

Under the provision, an employer is required to report on the Form W-2 of an employee each month with respect to which the employee is eligible for other specified coverage in connection with employment by the employer.

¹¹⁶ An employer may be subject to a reporting penalty if failing to provide the statement as required.

Penalty for claim of excess credit

The provision increases the penalty imposed on claims for refund or credit in excess of the amount allowable to 25 percent in the case of a claim relating to the refundable tax credit for health insurance coverage.

EFFECTIVE DATE

The provision is effective for months beginning after December 31, 2019, in taxable years ending after that date.

N. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAVINGS ACCOUNT INCREASED TO AMOUNT OF DEDUCTIBLE AND OUT-OF-POCKET LIMITATION (SEC. ____ 16 OF THE COMMITTEE PRINT AND SEC. 223 OF THE CODE)

PRESENT LAW

An individual with a high deductible health plan and no other health plan (other than a plan that provides certain permitted insurance or permitted coverage) may establish a health savings account (“HSA”). Subject to limits, contributions to an HSA made by or on behalf of an eligible individual are deductible in determining adjusted gross income of the individual (that is, an “above-the-line” deduction). Contributions to an HSA by an employer for an employee (including salary reduction contributions made through a cafeteria plan) are excludible from income and from wages for employment tax purposes.¹¹⁷ Distributions from an HSA for qualified medical expenses are not includible in gross income.

HSA contributions for a year are subject to basic dollar limits that are adjusted annually as needed to reflect annual cost-of-living increases. For 2017, the basic limit on contributions that can be made to an HSA for a year is \$3,400 in the case of self-only coverage and \$6,750 in the case of family coverage.¹¹⁸ The basic contribution limits are increased by \$1,000 for an eligible individual who has attained age 55 by the end of the taxable year (referred to as “catch-up contributions”).¹¹⁹ All HSA contributions are aggregated for purposes of the contribution limits.¹²⁰ The annual HSA contribution limit for an individual is generally the sum of the limits determined separately for each month (that is, 1/12 of the limit for the year, including the catch-up limit, if applicable), based on the individual’s status and health plan coverage as of the first day of the month.¹²¹

¹¹⁷ Secs. 106(d), 125, 3121(a)(2), 3231(e)(1), 3306(b)(2), 3401(a)(22).

¹¹⁸ Under section 4973, an excise tax applies to contributions in excess of the maximum contribution amount for the HSA. The excise tax generally is equal to six percent of the cumulative amount of excess contributions that are not distributed from the HSA.

¹¹⁹ Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

¹²⁰ In addition, contributions to Archer MSAs under section 220 reduce the annual HSA contribution limit.

¹²¹ Under a special rule, an individual who is an eligible individual during the last month of a taxable year is treated as having been an eligible individual for every month in the taxable year for purposes of computing the annual limit. Thus, the individual may contribute the maximum annual amount. However, if the individual ceases to be an eligible individual within a certain period, contributions that could not otherwise have been made are generally includible in income and are subject to a 10-percent additional tax.

A minimum annual deductible amount and a maximum on the sum of the annual deductible and out-of-pocket expenses (such as co-pays) apply to high deductible health plans, which are adjusted annually as needed to reflect cost-of-living increases. For 2017, the minimum deductible is \$1,300 in the case of self-only coverage and \$2,600 in the case of family coverage. In addition, for 2017, the sum of the deductible and out-of-pocket expenses must be no more than \$6,550 in the case of self-only coverage and no more than \$13,100 in the case of family coverage.

REASONS FOR CHANGE

The Committee continues to believe that the combination of high deductible health plans and HSA will help reduce health care costs. In furtherance of that goal, increasing the limits on HSA contributions will encourage more people to enroll in high deductible health plans and contribute to HSAs.

EXPLANATION OF PROVISION

The provision increases the basic limit on aggregate HSA contributions for a year to equal the maximum on the sum of the annual deductible and out-of-pocket expenses permitted under a high deductible health plan, which are, for 2017, \$6,550 in the case of self-only coverage and \$13,100 in the case of family coverage. As under present law, basic contribution limits are increased by \$1,000 for an eligible individual who has attained age 55 by the end of the taxable year. In addition, as under present law, the annual HSA contribution limit for an individual is generally the sum of the limits determined separately for each month (that is, 1/12 of the limit for the year, including the catch-up limit, if applicable), based on the individual's status and health plan coverage as of the first day of the month.

EFFECTIVE DATE

The provision applies for taxable years beginning after December 31, 2017.

O. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CONTRIBUTIONS TO THE SAME HEALTH SAVINGS ACCOUNT (SEC. ____17 OF THE COMMITTEE PRINT AND SEC. 223 OF THE CODE)

PRESENT LAW

An individual with a high deductible health plan and no other health plan (other than a plan that provides certain permitted insurance or permitted coverage) may establish an HSA. HSA contributions for a year are subject to basic dollar limits that are adjusted annually as needed to reflect annual cost-of-living increases. The basic contribution limits are increased by \$1,000 for an eligible individual who has attained age 55 by the end of the taxable year (referred to as "catch-up contributions"). If eligible individuals are married to each other and either spouse has family coverage, both spouses are treated as having only family coverage, so that the contribution limit for family coverage applies. The contribution limit (without regard to any catch-up contribution amounts) is divided

equally between the spouses unless they agree on a different division.

If both spouses of a married couple are eligible individuals, each may contribute to an HSA, but they cannot have a joint HSA.¹²² Under the rule described above, however, the spouses may divide their basic contribution limit for the year by allocating the entire amount to one spouse to be contributed to that spouse's HSA.¹²³ This rule does not apply to catch-up contribution amounts. Thus, if both spouses are at least age 55 and eligible to make catch-up contributions, each must make the catch-up contribution to his or her own HSA.¹²⁴

REASONS FOR CHANGE

The Committee continues to believe that the combination of high deductible health plans and HSAs will help reduce health care costs. The Committee has identified certain cases where it believes that the operation of HSAs can be improved. One such case involves the present-law obstacle that prevents both otherwise eligible spouses from making catch-up contributions if they have only one HSA account. The Committee wishes to make the operation of HSAs more efficient by allowing both eligible spouses to make catch-up contributions to a single HSA, rather than the present law requirement that they each must have their own HSA in order to make catch-up contributions.

EXPLANATION OF PROVISION

Under the provision, if both spouses of a married couple are eligible for catch-up contributions and either has family coverage, the annual contribution limit that can be divided between them includes catch-up contribution amounts of both spouses. Thus, for example, the spouses can agree that their combined basic and catch-up contribution amounts are allocated to one spouse to be contributed to that spouse's HSA. In other cases, as under present law, a spouse's catch-up contribution amount is not eligible for division between the spouses; the catch-up contribution must be made to the HSA of that spouse.

EFFECTIVE DATE

The provision applies for taxable years beginning after December 31, 2017.

P. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT (SEC. __18 OF THE COMMITTEE PRINT AND SEC. 223 OF THE CODE)

PRESENT LAW

Distributions from an HSA for qualified medical expenses are not includible in gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income

¹²² Notice 2004-50, 2004-2 C.B. 196, Q&A-63.

¹²³ Notice 2004-50, Q&A-32. Funds from that HSA can be used to pay qualified medical expenses for either spouse on a tax-free basis. Notice 2004-50, Q&A-36.

¹²⁴ Notice 2008-59, 2008-2 C.B. 123, Q&A-22.

and are subject to an additional tax of 20 percent. The 20-percent additional tax does not apply if the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (that is, age 65).

In order for a distribution from an HSA to be excludible as a payment for a qualified medical expense, the medical expense must be incurred on or after the date that the HSA is established.¹²⁵ Thus, a distribution from an HSA is not excludible as a payment for a qualified medical expense if the medical expense is incurred after a taxpayer enrolls in a high deductible health plan but before the taxpayer establishes an HSA.

REASONS FOR CHANGE

The Committee has identified certain cases where it believes that the operation of HSAs can be improved. One such case involves the typical lag between obtaining coverage under a high deductible health plan and the establishment of an HSA. Recognizing this lag, the Committee believes it is appropriate to allow medical expenses incurred after coverage is obtained under a high deductible health plan but prior to the establishment of the HSA to be paid for from the HSA and to be excludible from income, provided the HSA is established within 60 days of obtaining coverage under a high deductible health plan.

EXPLANATION OF PROVISION

Under the provision, if an HSA is established during the 60-day period beginning on the date that an individual's coverage under a high deductible health plan begins, then the HSA is treated as having been established on the date coverage under the high deductible health plan begins for purposes of determining if an expense incurred is a qualified medical expense. Thus, if a taxpayer establishes an HSA within 60 days of the date that the taxpayer's coverage under a high deductible health plan begins, any distribution from an HSA used as a payment for a medical expense incurred during that 60-day period after the high deductible health plan coverage began is excludible from gross income as a payment for a qualified medical expense even though the expense was incurred before the date that the HSA was established.

EFFECTIVE DATE

The provision applies with respect to coverage beginning after December 31, 2017.

¹²⁵ Notice 2004-2, 2004-1 C.B. 269, Q&A-26.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of the Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy on March 8, 2017.

The vote on the amendment by Mr. Neal to the amendment in the nature of a substitute to Subtitle ____: Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy, which would strike the repeal of the 0.9 percent Medicare tax increase, was not agreed to by a roll call vote of 23 nays to 16 yeas (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady		X	.....	Mr. Neal	X	.....	.....
Mr. Johnson	Mr. Levin	X	.....	.....
Mr. Nunes		X	.....	Mr. Lewis	X	.....	.....
Mr. Tiberi		X	.....	Mr. Doggett	X	.....	.....
Mr. Reichert		X	.....	Mr. Thompson	X	.....	.....
Mr. Roskam		X	.....	Mr. Larson	X	.....	.....
Mr. Buchanan		X	.....	Mr. Blumenauer	X	.....	.....
Mr. Smith (NE)		X	.....	Mr. Kind	X	.....	.....
Ms. Jenkins		X	.....	Mr. Pascrell	X	.....	.....
Mr. Paulsen		X	.....	Mr. Crowley	X	.....	.....
Mr. Marchant		X	.....	Mr. Davis	X	.....	.....
Ms. Black		X	.....	Ms. Sánchez	X	.....	.....
Mr. Reed		X	.....	Mr. Higgins	X	.....	.....
Mr. Kelly		X	.....	Ms. Sewell	X	.....	.....
Mr. Renacci		X	.....	Ms. DelBene	X	.....	.....
Mr. Meehan		X	.....	Ms. Chu	X	.....	.....
Ms. Noem		X	.....			
Mr. Holding		X	.....			
Mr. Smith (MO)		X	.....			
Mr. Rice		X	.....			
Mr. Schweikert		X	.....			
Ms. Walorski		X	.....			
Mr. Curbelo		X	.....			
Mr. Bishop		X	.....			

Mr. Tiberi's motion to table Mr. Pascrell's appeal of the ruling of the Chair was agreed to by a roll call vote of 23 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson .....	.....	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins	X	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

The vote on the amendment by Mr. Blumenauer to the amendment in the nature of a substitute to Subtitle ____: Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy, which would allow individual consumers the choice between the ACA's tax credits, or the American Health Care Act's tax credits, was not agreed to by a roll call vote of 23 yays to 16 yeas (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	Mr. Neal	X	.....	.....
Mr. Johnson	Mr. Levin	X	.....	.....
Mr. Nunes	X	.....	Mr. Lewis	X	.....	.....
Mr. Tiberi	X	.....	Mr. Doggett	X	.....	.....
Mr. Reichert	X	.....	Mr. Thompson	X	.....	.....
Mr. Roskam	X	.....	Mr. Larson	X	.....	.....
Mr. Buchanan	X	.....	Mr. Blumenauer	X	.....	.....
Mr. Smith (NE)	X	.....	Mr. Kind	X	.....	.....
Ms. Jenkins	X	.....	Mr. Pascrell	X	.....	.....
Mr. Paulsen	X	.....	Mr. Crowley	X	.....	.....
Mr. Marchant	X	.....	Mr. Davis	X	.....	.....
Ms. Black	X	.....	Ms. Sánchez	X	.....	.....
Mr. Reed	X	.....	Mr. Higgins	X	.....	.....
Mr. Kelly	X	.....	Ms. Sewell	X	.....	.....
Mr. Renacci	X	.....	Ms. DelBene	X	.....	.....
Mr. Meehan	X	.....	Ms. Chu	X	.....	.....
Ms. Noem	X	.....			
Mr. Holding	X	.....			
Mr. Smith (MO)	X	.....			
Mr. Rice	X	.....			
Mr. Schweikert	X	.....			
Ms. Walorski	X	.....			
Mr. Curbelo	X	.....			
Mr. Bishop	X	.....			

The vote on the amendment by Ms. DelBene to the amendment in the nature of a substitute to Subtitle ____: Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy, which would fully repeal the excise tax on high-cost employee health plans ("Cadillac tax"), was not agreed to by a roll call vote of 23 yays to 16 yeas (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	Mr. Neal	X	.....	.....
Mr. Johnson	Mr. Levin	X	.....	.....
Mr. Nunes	X	.....	Mr. Lewis	X	.....	.....
Mr. Tiberi	X	.....	Mr. Doggett	X	.....	.....
Mr. Reichert	X	.....	Mr. Thompson	X	.....	.....
Mr. Roskam	X	.....	Mr. Larson	X	.....	.....
Mr. Buchanan	X	.....	Mr. Blumenauer	X	.....	.....

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Smith (NE)		X	.....	Mr. Kind	X	.....	.....
Ms. Jenkins		X	.....	Mr. Pascrell	X	.....	.....
Mr. Paulsen		X	.....	Mr. Crowley	X	.....	.....
Mr. Marchant		X	.....	Mr. Davis	X	.....	.....
Ms. Black		X	.....	Ms. Sánchez	X	.....	.....
Mr. Reed		X	.....	Mr. Higgins	X	.....	.....
Mr. Kelly		X	.....	Ms. Sewell	X	.....	.....
Mr. Renacci		X	.....	Ms. DelBene	X	.....	.....
Mr. Meehan		X	.....	Ms. Chu	X	.....	.....
Ms. Noem		X	.....			
Mr. Holding		X	.....			
Mr. Smith (MO)		X	.....			
Mr. Rice		X	.....			
Mr. Schweikert		X	.....			
Ms. Walorski		X	.....			
Mr. Curbelo		X	.....			
Mr. Bishop		X	.....			

The vote on the amendment by Ms. Sewell to the amendment in the nature of a substitute to Subtitle ____: Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy, which would ensure that the American Health Care Act does not result in an increase in medical costs or taxes for certain farmers, was not agreed to by a roll call vote of 23 nays to 15 yeas (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady		X	.....	Mr. Neal	X	.....	.....
Mr. Johnson	Mr. Levin	X	.....	.....
Mr. Nunes		X	.....	Mr. Lewis	X	.....	.....
Mr. Tiberi		X	.....	Mr. Doggett	X	.....	.....
Mr. Reichert		X	.....	Mr. Thompson	X	.....	.....
Mr. Roskam		X	.....	Mr. Larson	X	.....	.....
Mr. Buchanan		X	.....	Mr. Blumenauer .....		.....	.....
Mr. Smith (NE)		X	.....	Mr. Kind	X	.....	.....
Ms. Jenkins		X	.....	Mr. Pascrell	X	.....	.....
Mr. Paulsen		X	.....	Mr. Crowley	X	.....	.....
Mr. Marchant		X	.....	Mr. Davis	X	.....	.....
Ms. Black		X	.....	Ms. Sánchez	X	.....	.....
Mr. Reed		X	.....	Mr. Higgins	X	.....	.....
Mr. Kelly		X	.....	Ms. Sewell	X	.....	.....
Mr. Renacci		X	.....	Ms. DelBene	X	.....	.....
Mr. Meehan		X	.....	Ms. Chu	X	.....	.....
Ms. Noem		X	.....			
Mr. Holding		X	.....			
Mr. Smith (MO)		X	.....			
Mr. Rice		X	.....			
Mr. Schweikert		X	.....			
Ms. Walorski		X	.....			
Mr. Curbelo		X	.....			
Mr. Bishop		X	.....			

The vote on the amendment by Mr. Davis to the amendment in the nature of a substitute to Subtitle ____: Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy, which would require that the credit apply only to health plans that include services from community providers, including rural providers, community health centers, and child hospitals, was not agreed to by a roll call vote of 23 nays to 16 yeas (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady		X		Mr. Neal	X		
Mr. Johnson				Mr. Levin	X		
Mr. Nunes		X		Mr. Lewis	X		
Mr. Tiberi		X		Mr. Doggett	X		
Mr. Reichert		X		Mr. Thompson	X		
Mr. Roskam		X		Mr. Larson	X		
Mr. Buchanan		X		Mr. Blumenauer	X		
Mr. Smith (NE)		X		Mr. Kind	X		
Ms. Jenkins		X		Mr. Pascrell	X		
Mr. Paulsen		X		Mr. Crowley	X		
Mr. Marchant		X		Mr. Davis	X		
Ms. Black		X		Ms. Sánchez	X		
Mr. Reed		X		Mr. Higgins	X		
Mr. Kelly		X		Ms. Sewell	X		
Mr. Renacci		X		Ms. DelBene	X		
Mr. Meehan		X		Ms. Chu	X		
Ms. Noem		X					
Mr. Holding		X					
Mr. Smith (MO)		X					
Mr. Rice		X					
Mr. Schweikert		X					
Ms. Walorski		X					
Mr. Curbelo		X					
Mr. Bishop		X					

The vote on the amendment by Ms. DelBene to the amendment in the nature of a substitute to Subtitle ____: Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy, which would strike and replace the underlying bill's repeal of the Small Business Tax, was not agreed to by a roll call vote of 23 nays to 16 yeas (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady		X		Mr. Neal	X		
Mr. Johnson				Mr. Levin	X		
Mr. Nunes		X		Mr. Lewis	X		
Mr. Tiberi		X		Mr. Doggett	X		
Mr. Reichert		X		Mr. Thompson	X		
Mr. Roskam		X		Mr. Larson	X		
Mr. Buchanan		X		Mr. Blumenauer	X		
Mr. Smith (NE)		X		Mr. Kind	X		
Ms. Jenkins		X		Mr. Pascrell	X		
Mr. Paulsen		X		Mr. Crowley	X		
Mr. Marchant		X		Mr. Davis	X		
Ms. Black		X		Ms. Sánchez	X		
Mr. Reed		X		Mr. Higgins	X		
Mr. Kelly		X		Ms. Sewell	X		
Mr. Renacci		X		Ms. DelBene	X		
Mr. Meehan		X		Ms. Chu	X		
Ms. Noem		X					
Mr. Holding		X					
Mr. Smith (MO)		X					
Mr. Rice		X					
Mr. Schweikert		X					
Ms. Walorski		X					
Mr. Curbelo		X					
Mr. Bishop		X					

The vote on the amendment by Ms. Sánchez to the amendment in the nature of a substitute to Subtitle ____: Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy, which would specify that health plans

cannot vary charges on the basis of gender, was not agreed to by a roll call vote of 23 nays to 16 yeas (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady		X		Mr. Neal	X		
Mr. Johnson				Mr. Levin	X		
Mr. Nunes		X		Mr. Lewis	X		
Mr. Tiberi		X		Mr. Doggett	X		
Mr. Reichert		X		Mr. Thompson	X		
Mr. Roskam		X		Mr. Larson	X		
Mr. Buchanan		X		Mr. Blumenauer	X		
Mr. Smith (NE)		X		Mr. Kind	X		
Ms. Jenkins		X		Mr. Pascrell	X		
Mr. Paulsen		X		Mr. Crowley	X		
Mr. Marchant		X		Mr. Davis	X		
Ms. Black		X		Ms. Sánchez	X		
Mr. Reed		X		Mr. Higgins	X		
Mr. Kelly		X		Ms. Sewell	X		
Mr. Renacci		X		Ms. DelBene	X		
Mr. Meehan		X		Ms. Chu	X		
Ms. Noem		X					
Mr. Holding		X					
Mr. Smith (MO)		X					
Mr. Rice		X					
Mr. Schweikert		X					
Ms. Walorski		X					
Mr. Curbelo		X					
Mr. Bishop		X					

Mr. Paulsen's motion to table Ms. Chu's appeal of the ruling of the Chair was agreed to by a roll call vote of 23 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X			Mr. Neal		X	
Mr. Johnson				Mr. Levin		X	
Mr. Nunes	X			Mr. Lewis		X	
Mr. Tiberi	X			Mr. Doggett		X	
Mr. Reichert	X			Mr. Thompson		X	
Mr. Roskam	X			Mr. Larson		X	
Mr. Buchanan	X			Mr. Blumenauer		X	
Mr. Smith (NE)	X			Mr. Kind		X	
Ms. Jenkins	X			Mr. Pascrell		X	
Mr. Paulsen	X			Mr. Crowley		X	
Mr. Marchant	X			Mr. Davis		X	
Ms. Black	X			Ms. Sánchez		X	
Mr. Reed	X			Mr. Higgins		X	
Mr. Kelly	X			Ms. Sewell		X	
Mr. Renacci	X			Ms. DelBene		X	
Mr. Meehan	X			Ms. Chu		X	
Ms. Noem	X						
Mr. Holding	X						
Mr. Smith (MO)	X						
Mr. Rice	X						
Mr. Schweikert	X						
Ms. Walorski	X						
Mr. Curbelo	X						
Mr. Bishop	X						

Amendment by Mr. Lewis to the amendment in the nature of a substitute to Subtitle ____: Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy, which would strike the entire section and replace it

with a set of principles for health reform legislation, was not agreed to by a roll call vote of 23 nays to 16 yeas (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady		X	.....	Mr. Neal	X	.....	.....
Mr. Johnson	Mr. Levin	X	.....	.....
Mr. Nunes		X	.....	Mr. Lewis	X	.....	.....
Mr. Tiberi		X	.....	Mr. Doggett	X	.....	.....
Mr. Reichert		X	.....	Mr. Thompson	X	.....	.....
Mr. Roskam		X	.....	Mr. Larson	X	.....	.....
Mr. Buchanan		X	.....	Mr. Blumenauer	X	.....	.....
Mr. Smith (NE)		X	.....	Mr. Kind	X	.....	.....
Ms. Jenkins		X	.....	Mr. Pascrell	X	.....	.....
Mr. Paulsen		X	.....	Mr. Crowley	X	.....	.....
Mr. Marchant		X	.....	Mr. Davis	X	.....	.....
Ms. Black		X	.....	Ms. Sánchez	X	.....	.....
Mr. Reed		X	.....	Mr. Higgins	X	.....	.....
Mr. Kelly		X	.....	Ms. Sewell	X	.....	.....
Mr. Renacci		X	.....	Ms. DelBene	X	.....	.....
Mr. Meehan		X	.....	Ms. Chu	X	.....	.....
Ms. Noem		X	.....			
Mr. Holding		X	.....			
Mr. Smith (MO)		X	.....			
Mr. Rice		X	.....			
Mr. Schweikert		X	.....			
Ms. Walorski		X	.....			
Mr. Curbelo		X	.....			
Mr. Bishop		X	.....			

The legislation was ordered favorably transmitted to the House Committee on the Budget as amended by a roll call vote of 23 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson .....	.....	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins	X	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

IV. BUDGET EFFECTS OF THE PROVISIONS

A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the “Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy.”

The budget reconciliation legislative recommendations, as transmitted, are estimated to have the following effects on budget receipts for fiscal years 2017–2026:

ESTIMATED REVENUE EFFECTS OF BUDGET RECONCILIATION LEGISLATIVE RECOMMENDATIONS RELATING TO REPEAL AND REPLACEMENT OF CERTAIN HEALTH-RELATED TAX POLICY PROVISIONS CONTAINED IN THE "AFFORDABLE CARE ACT ('ACA')," AS REPORTED BY THE COMMITTEE ON WAYS AND MEANS

[Fiscal years 2017–2026, billions of dollars]

Provision	Effective	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–21	2017–26
Revenue Provisions:													
1. Modifications and repeal of premium tax credit:	(1)												
2. Small business tax credit	(2)												
3. Repeal of individual mandate penalty	mba 12/31/15												
4. Repeal of employer mandate penalty	mba 12/31/15												
5. Repeal of tax on employee health insurance premiums and health plan benefits; repeal 40% excise tax on health coverage in excess of \$10,200/\$27,500 (subject to adjustment for unexpected increase in medical costs prior to effective date) and increased thresholds of \$1,650/\$3,450 for over age 55 retirees or certain high-risk professions, both indexed for inflation by CPI–U (CPI–U plus 1% for 2019); adjustment based on age and gender profile of employees; vision and dental excluded from excise tax levied at insurer level; employer aggregates and issues information return for insurers indicating amount subject to the excise tax (repeal sunsets 12/31/24) ^{3,4}	tyba 12/31/19				– 3.4	– 6.9	– 8.7	– 10.7	– 13.6	– 5.5		– 10.3	– 48.7
6. Repeal exclusion of nonprescribed over-the-counter medicines from the definition of medical expenses for health savings accounts ("HSAs"), Archer MSAs, health flexible spending arrangements, and health reimbursement arrangements ^{4,5}	apaeiwrt tyba 12/31/17		– 0.4	– 0.5	– 0.6	– 0.6	– 0.6	– 0.6	– 0.7	– 0.7	– 0.7	– 2.1	– 5.5
7. Repeal increase in additional tax on distributions from HSAs and Archer MSAs not used for qualified medical expenses ⁵	dma 12/31/17		(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	– 0.1
8. Repeal limitations on contributions to health flexible spending arrangements in cafeteria plans ^{4,5}	tyba 12/31/17		– 0.3	– 1.2	– 1.6	– 1.7	– 1.8	– 2.2	– 2.6	– 3.3	– 4.1	– 4.7	– 18.6
9. Repeal 2.3% excise tax on manufacturers and importers of certain medical devices	sa 12/31/17		– 1.4	– 1.9	– 2.0	– 2.1	– 2.2	– 2.3	– 2.4	– 2.6	– 2.7	– 7.4	– 19.6
10. Reinstate deduction for expenses allocable to Medicare Part D subsidy	tyba 12/31/17		– 0.1	– 0.2	– 0.2	– 0.2	– 0.2	– 0.2	– 0.2	– 0.2	– 0.2	– 0.6	– 1.7
11. Extend the 7.5% AGI floor in 2017 for elderly taxpayers and repeal increase in AGI floor on medical expenses deduction from 7.5% to 10%; apply 7.5% floor for alternative minimum tax purposes	tyba 12/31/16 & tyba 12/31/17	– 0.2	– 2.0	– 3.2	– 3.4	– 3.6	– 3.9	– 4.2	– 4.5	– 4.8	– 5.1	– 12.4	– 34.9

ESTIMATED REVENUE EFFECTS OF BUDGET RECONCILIATION LEGISLATIVE RECOMMENDATIONS RELATING TO REPEAL AND REPLACEMENT OF CERTAIN HEALTH-RELATED TAX POLICY PROVISIONS CONTAINED IN THE "AFFORDABLE CARE ACT ('ACA')," AS REPORTED BY THE COMMITTEE ON WAYS AND MEANS—Continued

[Fiscal years 2017–2026, billions of dollars]

Provision	Effective	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–21	2017–26
12. Repeal additional HI tax of 0.9% on earned income in excess of \$200,000/ \$250,000 (unindexed)	rra & tyla 12/ 31/17	–0.4	–6.5	–10.1	–11.4	–12.3	–13.2	–14.1	–15.2	–16.5	–17.6	–40.8	–117.3
13. Refundable health credit for health insurance coverage	mba 12/31/19 in tyla sd												
14. Maximum contribution limit to HSA increased to amount of deductible and out-of-pocket limitation ⁴	tyla 12/31/17	–1.0	–1.6	–1.7	–1.9	–2.1	–2.3	–2.5	–2.7	–2.9	–2.9	–6.2	–18.6
15. Allow both spouses to make catch-up contributions to the same HSA ⁴	tyla 12/31/17	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	–0.1	–0.1	–0.1	–0.4
16. Special rule for certain medical expenses incurred before establishment of HSA ⁴	cba 12/31/17	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	–0.1	–0.2
Net total		–0.6	–11.7	–18.7	–24.3	–29.3	–32.7	–36.6	–41.7	–36.4	–33.4	–84.7	–265.6

Note: Details may not add to totals due to rounding. The date of enactment is assumed to be before April 1, 2017.

Legend for "Effective" column: apaeiwt = amounts paid and expenses incurred with respect to; mba = months beginning after; sd = such date; cba = coverage beginning after; rra = remuneration received after; tyla = taxable years beginning after; dnta = distributions made after; sa = sales after; tyla = taxable years ending after.

¹ This provision is effective for months beginning after December 31, 2019, in taxable years ending after such date and subsection (b) shall take effect on January 1, 2020.

² This provision is effective for taxable years beginning after December 31, 2017, and taxable years beginning after December 31, 2019.

³ This estimate does not include effects of interactions with other subsidies; those effects are included in estimates of other relevant provisions.

⁴ Estimate includes the following off-budget effects:

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–21	2017–26
Repeal 40% excise tax on health coverage	–0.8	–1.4	–1.9	–2.4	–3.0	–1.0	.....	–2.3	–10.5
Repeal exclusion of nonprescribed over-the-counter medicines from the definition of medical expenses	–0.1	–0.1	–0.1	–0.1	–0.2	–0.2	–0.2	–0.2	–0.2	–0.5	–1.3
Repeal limitation on health flexible spending arrangements to cafeteria plans	–0.3	–0.5	–0.5	–0.5	–0.6	–0.7	–0.9	–1.2	–1.1	–1.8	–6.4
Maximum contribution limit to HSA increased to amount of deductible and out-of-pocket limitation	–0.2	–0.4	–0.4	–0.4	–0.5	–0.5	–0.6	–0.6	–0.7	–1.4	–4.3
Allow both spouses to make catch-up contributions to the same HSA	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	–0.1
Special rule for certain medical expenses incurred before establishment of HSA	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	(⁶)	–0.1

⁵ This estimate includes the effects of interactions with the proposal to increase the maximum contribution limit to HSAs.

⁶ Loss of less than \$50 million.

Pursuant to clause 8 of rule XIII of the Rules of the House of Representatives, the following statement is made by the Joint Committee on Taxation with respect to the provisions of the budget reconciliation legislative recommendations amending the Internal Revenue Code of 1986: While the bill meets the standard of major legislation, it is not practicable to incorporate the macroeconomic effects of the bill in the official cost estimate, given current time constraints.

**B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX
EXPENDITURES BUDGET AUTHORITY**

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the budget reconciliation legislative recommendations relating to a refundable tax credit for the purchase of health insurance and deposit of an amount into an individual's HSA involve new or increased budget authority. The Committee states further that the budget reconciliation legislative recommendations relating to the premium tax credit and the small business tax credit involve reduced tax expenditures. The Committee also states that the budget reconciliation legislative recommendations relating to repeal of limits on certain exclusions and deductions, repeal of various taxes, provision of a new refundable tax credit for the purchase of health insurance, and changes to the rules for health savings accounts involve new or increased tax expenditures.

**C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET
OFFICE**

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, refer to Subtitle E.

**V. OTHER MATTERS TO BE DISCUSSED UNDER THE
RULES OF THE HOUSE**

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee advises that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated into the description portions of this report.

B. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the budget reconciliation legislative recommendations contain no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizing funding is required.

C. INFORMATION RELATING TO UNFUNDED MANDATES

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104-4).

The Committee has determined that the budget reconciliation legislative recommendations relating to recapture of excess advance payments of premium tax credits and the small business tax credit impose private sector mandates. The Committee has determined that the budget reconciliation legislative recommendations do not impose any Federal intergovernmental mandates on State, local, or tribal governments.

D. APPLICABILITY OF HOUSE RULE XXI 5(b)

Rule XXI 5(b) of the Rules of the House of Representatives provides, in part, that “A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting, a quorum being present.” The Committee has carefully reviewed the provisions of the budget reconciliation legislative recommendations and states that the provisions of the legislative recommendations do not involve any Federal income tax rate increases within the meaning of the rule.

E. TAX COMPLEXITY ANALYSIS

Section 4022(b) of the Internal Revenue Service Restructuring and Reform Act of 1998 (“IRS Reform Act”) requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses. For each such provision identified by the staff of the Joint Committee on Taxation, a summary description of the provision is provided below along with an estimate of the number and type of affected taxpayers, and a discussion regarding the relevant complexity and administrative issues. Following the analysis of the staff of the Joint Committee on Taxation are the comments of the IRS and Treasury regarding each provision included in the complexity analysis.

1. Repeal of Tax on Over-The-Counter Medications

Summary description of the provisions

The provision allows payment or reimbursement on a pretax basis from a health flexible spending arrangement, health reimbursement arrangement, health savings account or Archer MSA, of the cost of an over-the-counter medicine without requiring a prescription for the medicine.

Number of affected taxpayers

It is estimated that the provision will affect over ten percent of individual tax returns.

Discussion

Taxpayers voluntarily claiming reimbursement for over-the-counter medicines may have an increased burden in record-keeping and claim submissions. It is expected that revisions to IRS published guidance and tax publications will be required.



COMMISSIONER

DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224

March 14, 2017

Mr. Thomas A. Barthold
Chief of Staff
Joint Committee on Taxation
Washington, D.C. 20515

Dear Mr. Barthold:

I am responding to your letter dated March 10, 2017, in which you requested a complexity analysis related to Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy.

Enclosed are the combined comments of the Internal Revenue Service (IRS) and the Treasury Department for inclusion in the complexity analysis in the House Committee on Ways and Means report on the Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy.

Our analysis covers the one provision that you preliminarily identified in your letter: Repeal of Tax on Over-the-Counter Medications. Please note that for purposes of this complexity analysis, IRS staff assumed timely enactment of this legislation. If legislation is not enacted before the end of the year, there would be complexity for IRS and for taxpayers that is not addressed in this response.

Finally, I note that our enclosed analysis is limited to the provision of the bill identified in your letter. However, other aspects of the bill could impose significant costs and administrative burden on the IRS. In particular, the bill transfers authority for the advance payment program from the Department of Health and Human Services (HHS) to the Treasury Department beginning in 2020 and expands the definition of a "qualified health plan" beginning in 2018. HHS has expertise in administering health policy; IRS does not. HHS has processes in place and existing relationships with states, insurance providers, brokers, agents and other government agencies to carry out its administration of health insurance subsidies. The IRS, as a tax administration agency, lacks these processes and relationships. The bill appears to greatly expand IRS's current responsibilities. The IRS anticipates that implementation of the bill could result in substantial costs for new systems, acquiring experience and expertise in health insurance, and implementation of new processes. We have not yet fully evaluated these costs.

Sincerely,

A handwritten signature in dark ink, appearing to read "John A. Koskinen".

John A. Koskinen

Enclosure

**COMPLEXITY ANALYSIS OF THE COMMITTEE REPORT ON THE BUDGET
RECONCILIATION LEGISLATIVE RECOMMENDATIONS RELATING TO REPEAL
AND REPLACE OF HEALTH-RELATED TAX POLICY**

The provision allows payment or reimbursement on a pretax basis from a health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and health saving account (HSA) or Archer medical savings account (MSA), of the cost of an over-the-counter medicine without requiring a prescription for the medicine.

IRS and Treasury Comments:

- Development of a new form or forms is not necessary.
- IRS would need to revise publications and instructions to reflect the broadening of the definition of medical expenses. Specifically, the following publications and instructions would require revision: Publication 505 Tax Withholding and Estimated Tax; Publication 969 Health Savings Accounts and Other Tax-Favored Health Plans; Form 1040 Schedule A Instructions; Form 1040ES Instructions; Form 1040ES PR Instructions; Form 8889 Health Savings Account Instructions.
- IRS would need to develop a comprehensive communication strategy to ensure that IRS employees and taxpayers understand the change.
- Taxpayers voluntarily claiming FSA reimbursement for over-the-counter medicines would incur some extra burden in record keeping and filing claims for reimbursement, potentially for small amounts of money.
- Record keeping burden on pharmacies may be reduced depending on their current plan requirements.
- Guidance under sections 105 and 106 would also be needed.

F. CONGRESSIONAL EARMARKS, LIMITED TAX BENEFITS, AND
LIMITED TARIFF BENEFITS

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the budget reconciliation legislative recommendations and states that the provisions of the legislative recommendations do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

G. DUPLICATION OF FEDERAL PROGRAMS

In compliance with clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee states that the budget reconciliation legislative recommendation does not establish or reauthorize: (1) a program of the Federal Government known to be duplicative of another Federal program, (2) a program included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111-139, or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to section 6104 of title 31, United States Code.

H. DISCLOSURE OF DIRECTED RULE MAKINGS

In compliance with Sec. 3(i) of H. Res. 5 (115th Congress), the following statement is made concerning directed rule makings: The Committee advises that the budget reconciliation legislative recommendations require no directed rule makings within the meaning of such section.

**VI. CHANGES IN EXISTING LAW MADE BY THE BUDGET
RECONCILIATION LEGISLATIVE RECOMMENDATION, AS
TRANSMITTED**

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes to existing law made by the recommendations, as transmitted, are shown in Subtitle E of title II.

VII. DISSENTING VIEWS

DISSENTING VIEWS ON RECOMMENDATION TO REPEAL AND REPLACE THE AFFORDABLE CARE ACT, COMMITTEE PRINT 5

1. Donald Trump promised that “we’re going to have insurance for everybody . . . [but it will be] much less expensive and much better.” This bill reveals those promises for what they always were: empty campaign rhetoric.”—Families USA¹

2. “We cannot support the AHCA as drafted because of the expected decline in health insurance coverage and the potential harm it would cause to vulnerable patient populations.”—American Medical Association²

3. “Repeal-and-replace is a gigantic transfer of wealth from the lowest-income Americans to the highest-income Americans.”—Edward D. Kleinbard, former chief of staff for the Joint Committee on Taxation and professor, University of Southern California School of Law.³

The five reconciliation legislative recommendations considered by the Committee on Ways and Means (the “Committee”) and referred to the Committee on Budget (collectively, the Ways and Means reconciliation package or the “reconciliation package”) was a far-reaching attempt to undermine our health systems from Medicare to employer sponsored health insurance in order to give tax cuts to the wealthiest and corporations. After almost 18 hours of debate, the Committee mark-up ended with a party-line vote on the reconciliation package, which is likely to take health insurance away from millions of Americans. This reconciliation package, coupled with what was passed out of the Energy and Commerce Committee, would harm access to health care for middle-class Americans and undermine Medicare’s long-term viability while cutting taxes for corporations and the wealthiest Americans.

The Committee moved forward irresponsibly, without any official accounting about the estimated effect of the reconciliation package on health insurance coverage, out-of-pocket costs, or premium increases. While the Joint Committee on Taxation (JCT) estimated that the reconciliation package includes nearly \$600 billion worth of tax breaks, as of the mark-up, the Congressional Budget Office (CBO) was unable to provide estimates about the package’s effect on American families. Additionally the JCT score was incomplete as of the mark-up and did not provide an official accounting of all of the provisions considered by the Committee. Both the Ways and Means and Energy and Commerce Committees moved forward to

¹ <http://familiesusa.org/blog/2017/03/healthy-and-wealthy-benefit-under-house-republican-affordable-care-act-repeal-plan>

² <https://www.ama-assn.org/sites/default/files/media-browser/public/washington/ama-letter-on-ahca.pdf>

³ https://www.nytimes.com/2017/03/10/business/tax-cuts-affordable-care-act-repeal.html?_r=1

pass recommendations out of each Committee without any sense from CBO of coverage losses due to the severe cuts to Medicaid, the repeal of the individual and employer-shared responsibility provisions of current law, or the changes in the tax credits available to help purchase health insurance on the individual market.

CBO provided the Committee an estimate of the effects *after* the reconciliation package was reported to the Committee on Budget from the Ways and Means and Energy and Commerce Committees. This estimate showed that 24 million Americans would lose coverage, with 14 million Americans losing coverage in the first year alone.

The Committee's reconciliation package provided generous tax cuts to the wealthiest, while reducing health insurance assistance for middle-class Americans. The tax breaks considered by the Committee are focused on the wealthy individuals and corporations, instead on middle-class Americans. About \$275 billion in tax breaks would benefit high-income earners; about 62% of the tax breaks would go to millionaires in 2020. Businesses and corporations are receive nearly \$192 billion in tax cuts. These and other tax breaks add up to nearly \$600 billion in lost revenue.

Democrats objected strenuously to the Republican approach and instead believe the Committee should focus on policies that matter to middle-class Americans under the jurisdiction of this Committee, including financing long-term infrastructure, reforming the tax system to address income inequality, and further building on President Obama's record of job creation. Democrats believe that the reconciliation package will destabilize the health insurance market, which represents 18 percent of our gross domestic product.

The reconciliation package continues Republican efforts to undermine and destabilize the health insurance market. It undermines current law and the stability of both the individual and group health insurance markets by gutting individual and employer-shared responsibility provisions. The reconciliation package would reduce the uptake of the premium tax credits and the Medicaid expansion established in the Affordable Care Act (ACA), which have made health care affordable for millions of individuals. Reduced uptake of the Medicaid expansion and the tax credits disproportionately impacts low- and middle-income Americans and places them at risk for health insecurity and unexpected medical expenses. Based on independent estimates, roughly 24 million Americans would lose their insurance coverage because of this reconciliation package when taken together with the reconciliation recommendations passed by the Energy and Commerce Committee.⁴ Further, this reconciliation package reduces the life of the Medicare Trust Fund by three years by reducing \$170 billion from the Medicare Trust Fund, which puts Medicare at risk for 57 million seniors and individuals with disabilities.

Individual and employer-shared responsibility provisions are key to maintaining the robust and healthy risk pools that allow the ACA health insurance reforms to improve consumer protections while controlling health care costs. This is because well-functioning

⁴ <https://www.brookings.edu/blog/up-front/2017/03/09/expect-the-cbo-to-estimate-large-coverage-losses-from-the-gop-health-care-plan/>

insurance markets rely on participation of both healthy and sick individuals to spread risk across the pool.

The reconciliation package effectively would repeal the individual and employer-shared responsibility penalty, leading to premium increases of an estimated 20 percent in the individual market alone. In spite of President Trump and Congressional Republicans' efforts to sabotage the ACA, millions of Americans have enrolled in the health insurance Marketplaces, many using the available financial assistance, and millions more have enrolled in expanded Medicaid programs.

Despite promises made by President Trump, the reconciliation package would not cover more people or offer more affordable coverage with comparable benefits. Instead, this package leads to an estimated coverage loss of 24 million people while gutting benefits and consumer protections as a mechanism for affordability. When coupled with the legislation passed out of the Energy and Commerce Committee, the reconciliation package would return to a time when the market once again discriminates against those with pre-existing conditions and leaves those that might need medical care in the future without meaningful coverage. The reconciliation package provides for tax credits less generous than current law with no assistance with out-of-pocket expenses. Instead, the reconciliation package enshrines high deductible health plans that would increase out-of-pocket expenses. However, these plans do not address the underlying issues of access to quality services and the cost of care.

Since January of 2009, the Republicans voted to repeal or undermine the ACA more than 65 times. Democrats offered a number of amendments in Committee to point out serious flaws with the reconciliation package. For example, at the beginning of the mark up, Democrats asked Republicans to postpone mark up until CBO could provide a comprehensive report on costs, coverage losses, and premium effects of the reconciliation package.

In that regard, Congressman Lloyd Doggett (D-TX) offered a motion to postpone the markup for one week to allow time for review of the bill and the CBO estimate that was not available prior to or during the mark up. For over four decades, CBO has been recognized as the official referee of costs and effects of legislation passed in the House and Senate. Congress relies on CBO's non-partisan estimates to evaluate legislative proposals. Democrats were concerned that Republicans deliberately moved forward with the reconciliation package without a CBO score in an effort to conceal the harmful effects of the reconciliation package on nearly all Americans.

The contrast of this rushed process versus the lengthy and transparent process of enacting the ACA is striking. In 2009, House Committees posted a draft of the ACA legislation for review and comment a month before the mark-up process began, holding multiple hearings and providing the public with two preliminary CBO estimates on July 8th and July 14th. Democrats maintain that there is no reason to rush to mark-up this reconciliation package without a CBO score, or without a hearing to consider the implications of the package. Congressman Doggett's amendment was tabled on a party line vote.

Since taking office President Trump has initiated a number of actions that continue a pattern of trying to sabotage the ACA. In January, President Trump issued an Executive Order to direct agencies to take action to “eliminate burden.” The Trump Administration cancelled ACA outreach in the last two weeks of the 2017 individual market open enrollment period. Prior to that, 2017 Marketplace enrollment was outpacing 2016 enrollment. Final enrollment came in slightly lower. On February 15, 2017, CMS issued a proposed Marketplace rule that makes it more expensive and more difficult to get coverage, including cutting the open enrollment period in half. Per President Trump’s Executive Order, the Internal Revenue Service (IRS) issued a February 14, 2017 statement on non-enforcement of the individual mandate in processing tax returns. This change in enforcement would undermine stability in the marketplace by preventing the IRS from using new tools to enforce the individual responsibility provision of the ACA—a crucial part of keeping a healthier pool and keeping premiums affordable.⁵

Nevertheless, the current marketplace is benefitting consumers. Of the approximately 10.4 million consumers who had effectuated Marketplace enrollments: 84 percent, or about 8.8 million consumers, were receiving advance premium tax credits and 56 percent or nearly 5.9 million consumers were benefiting from cost sharing reductions (CSRs) to make their coverage and covered services more affordable.

In addition to new coverage options Americans gained under the ACA, the pace of health spending has been moderated under the ACA. Overall, health care spending growth slowed from 5.8% in 2015 to 4.8% in 2016 due to slowdowns in Medicaid and prescription drug spending. Private health insurance spending slowed from 7.2% in 2015 to 5.9% in 2016. Health spending is projected to grow an average of 5.6 percent between 2016 and 2025; well below the average over the previous two decades before 2008, which was nearly 8 percent.⁶

While some areas of the country experienced atypical premium increases, many analysts believed they were a one-time correction: “One factor contributing to faster growth is a significant acceleration in premium growth for Marketplace plans because of previous underpricing of premiums and elimination of risk corridor payments.”⁷

Concern is growing, however, that under the Republican plan premiums will grow substantially. J. Mario Molina, chief executive of Molina Healthcare Inc., believes that the recent Republican actions to undo the mandate could help push individual-plan premiums up by 30% or more next year and they could rise considerably more in the future, when the reduced federal assistance for low-income enrollees kicks in. He noted, “You’re going to see big rate increases, and you’re going to see insurers exit markets . . . this is going to destabilize the marketplace,” he said.⁸

⁵ <http://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca>

⁶ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2016.pdf>

⁷ Keehan et al. “National Health Expenditure Projections, 2016–25: Price Increases, Aging Push Sector To 20 Percent Of Economy,” *Health Aff* March 2017 vol. 36 no. 3 553–563.

⁸ <https://www.wsj.com/articles/what-insurers-like-and-dread-about-gops-plan-to-replace-obamacare-1488906247>

Other analysts concur that the Republican plan would result in coverage losses. “We conclude that CBO’s analysis will likely estimate that at least 15 million people will lose coverage under the American Health Care Act (AHCA) by the end of the ten-year scoring window. Estimates could be higher, but it’s unlikely they will be significantly lower,” wrote Brookings Institute researchers who modeled the Republican bill.⁹

Given the far-reaching impact on the Republican reconciliation package to harm Medicare, Medicaid, employer-sponsored insurance and the individual insurance market, Democrats offered a series of amendments to address and highlight the serious shortcomings of the Republican plan. All amendments were defeated in partisan votes.

I offered an amendment to strike the repeal of the high-earner tax that goes into the Medicare Trust Fund. The independent Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS) found that repealing this tax would take \$170 billion from the Medicare Trust Fund, shortening the program’s solvency by three years. This tax cut for the highest income earners hurts Medicare’s long-term financial footing just as America’s baby boomers are becoming Medicare eligible. The ACA, on the other hand, extended Medicare solvency by 11 years. Since Medicare was enacted, the poverty rate for seniors dropped by 70 percent. In 1966, the first year of Medicare, 28.5 percent of seniors were in poverty; in 2015, that figure dropped to 8.8 percent.¹⁰ Before Medicare was enacted, about half of all seniors did not have health insurance.¹¹ Since the advent of Medicare and Medicaid, nearly all have Medicare and/or Medicaid. Over three-quarters of Americans support Medicare and believe it is very important. With low administrative costs, broad choice of care, and affordable cost-sharing, there is good reason for Medicare’s popularity. The Republicans are attacking Medicare, slashing Medicare funding without providing anything to improve Medicare, or access to care for seniors and individuals with disabilities. Instead, this legislation provides tax cuts for the wealthy and corporations, while cutting Medicare funding and taking three years off of the life of the Medicare trust fund. This is another provision that would increase costs for seniors and older Americans. The Democratic amendment to restore the funding to Medicare was defeated on a party line vote of 23–16.

Congressman Pascrell (D–NJ) offered an amendment to provide a Sense of Congress that Congress should not cap Medicaid funding and shift costs, and that Congress should protect the Medicaid expansion. Medicaid, while not in the jurisdiction of the Committee on Ways and Means, is an important part of coverage for 16 million Medicare-eligible Americans. For seniors and people with disabilities, Medicaid is the primary source of long-term care coverage, and 70 percent of all nursing home residents rely on Medicaid.¹² The Republican reconciliation recommendation to cap the Medicaid

⁹ <https://www.brookings.edu/blog/up-front/2017/03/09/expect-the-cbo-to-estimate-large-coverage-losses-from-the-gop-health-care-plan/#fn1>

¹⁰ <http://www.census.gov/data/tables/time-series/demo/income-poverty/historical1-poverty-people.html>

¹¹ <https://www.cms.gov/Outreach-and-Education/Look-Up-Topics/50th-Anniversary/50-Facts-in-50-Days-Pt1.pdf>

¹² Families USA, Medicaid (<http://familiesusa.org/issues/medicaid>).

program threatens this important safety-net for people needing long-term services and support.

Medicaid expansion serves a critical role in providing health insurance to those who otherwise cannot afford it and would remain uninsured. Medicaid provides high quality coverage that improves the lives of its beneficiaries. For individuals gaining coverage because of the Medicaid expansion, access to primary care and treatment for chronic conditions have increased, and rates of skipping medications to save money have decreased.¹³ This new coverage, combined with coverage expansions through the Marketplaces and other coverage improvements the ACA made, has helped drive the uninsured rate to the lowest level in our nation's history.

Republicans refused to support a simple resolution calling for the protection of coverage for more than 70 million Americans. The nearly \$600 billion in tax breaks for the wealthiest individuals and corporations in the reconciliation package are paid for by starving health coverage for 70 million Americans and slashing funding by \$370 billion. Nevertheless, Chairman Brady ruled the amendment was not in order.

Congressman Blumenauer (D-OR) offered an amendment that would provide Americans with the choice of keeping tax credits provided under the ACA or receiving tax credits provided under this Republican health care bill. Independent analyses show that low-income people, older Americans, Americans with health conditions and those who live in high-cost areas stand to lose financial protection, benefits and choice under the Republican plan.¹⁴ Moreover, the Republican tax credits are insufficient and simply shift more costs onto middle-class Americans. Flat tax credits diminish in value over time, decreasing the amount of coverage that families can buy. This problem is particularly acute in high-cost areas like rural communities where the value of the tax credit would not keep up with the cost of care. The Department of Health and Human Services conducted an analysis on just this issue and informed me of the findings. This analysis shows that under the ACA, nearly three-quarters of Americans in 2017 can find health insurance coverage for \$75 or less a month in the ACA Marketplace. If we replace the analysis with the Republican tax credits, the share drops from nearly 75 percent to 46 percent—a roughly sixty percent drop in the number of Americans who are able to find affordable insurance coverage. More Americans will have to pay more to get less comprehensive coverage under the Republican plan. Americans should not be forced into this one-size-fits-all approach. This amendment would allow Americans to keep their coverage tax credits and coverage if they prefer the tax credits they currently have. This amendment was similarly defeated.

Congresswoman DelBene (D-CA) offered an amendment to repeal the high-cost plan excise tax (often called the “Cadillac tax”).

¹³ Benjamin D. Sommers, et al., Changes in utilization and health among low-income adults after Medicaid expansion or expanded private insurance, *JAMA Internal Medicine* (Oct. 2016) <https://www.ncbi.nlm.nih.gov/pubmed/27532694>.

¹⁴ <https://www.nytimes.com/interactive/2017/03/08/upshot/who-wins-and-who-loses-under-republicans-health-care-plan.html> ? r=0

<http://www.aarp.org/ppi/info-2017/affordable-care-act-protects-millions-of-older-adults-with-pre-existing-conditions.html>

<http://www.vox.com/the-big-idea/2017/2/24/14722152/obamacare-aca-health-care-costs-premiums-costs-increase>

As noted other dissenting views, Congresswoman Sanchez (D-CA) offered an amendment to repeal the Cadillac Tax that was ruled non-germane during the mark-up of Committee Print 1. The amendment was germane when offered in Committee Print 5, as the Republican bill delays implementation of the tax until 2025. While Republicans have put forward a package with nearly \$600 billion in tax cuts for corporations and wealthy Americans, they have left in place the tax on employee benefits.

The tax unfairly reduces health benefits for employees who have these plans, particularly those with expensive chronic illnesses. The AFL-CIO noted, "Far from providing an improvement on the coverage provided by the ACA, this Republican alternative will result in millions of Americans losing their coverage. . . . Estimates from the Mercer Firm find that by the time the AHCA imposes the tax in 2025, the coverage provided by more than 40% of employers with 50+ workers would be impacted by the tax. CBO predicts that the vast majority of 14 employers confronted with this tax are expected to shift costs to their workers by increasing deductibles, copays, co-insurance, and maximum out of pocket limits to avoid paying the tax."¹⁵ While in the 114th Congress, 300 members of the House of Representatives, nearly 70 percent, have signed on to legislation to fully repeal the Cadillac tax, the amendment was defeated 16-23.

Congresswoman Sewell (D-AL) offered an amendment to protect farmers in rural areas from coverage loss under the Republican legislation. More than 50 million Americans live in rural areas and have significantly benefitted from the ACA through greater insurance coverage. Rural individuals saw greater gains in insurance coverage compared with urban individuals (7.2 percentage point increase versus 6.3 percentage point increase for urban areas)¹⁶ and some rural communities experienced even larger decreases.¹⁷ This drop in uninsured occurred even though uninsured rural individuals disproportionately live in states that have not expanded Medicaid.¹⁸ Due to the physically taxing and hazardous nature of their work, small family farmers had a particularly tough time before the ACA getting health insurance for themselves and their families. The majority of them are self-employed and do not make enough to cover the costs. The ACA provided family farmers with cost-sharing subsidies, premium tax credits, and access to coverage that they were not guaranteed before. Rural communities would be among the hardest hit if Republicans repeal the ACA. This amendment was defeated.

Congresswoman Sanchez (D-CA) offered an amendment that would disallow health savings accounts (HSA) expenditures by sex-offenders to purchase pharmaceuticals treating erectile dysfunction. The Republican reconciliation package greatly expands the amount of funds that can be contributed to tax-preferred HSAs and the types of health related expenditures that can be reimbursed

¹⁵ AFL-CIO letter from William Samuels to Congresswoman Sanchez, March 8, 2017.

¹⁶ <http://hrms.urban.org/quicktakes/Substantial-Gains-in-Health-Insurance-Coverage-Occurring-for-Adults-in-Both-Rural-and-Urban-Areas.html>

¹⁷ <http://www.npr.org/sections/health-shots/2016/11/19/502580120/in-depressed-rural-kentucky-worries-mount-over-medicare-cutbacks>

¹⁸ <https://aspe.hhs.gov/sites/default/files/pdf/204986/ACARuralbrief.pdf>

through a health-related tax-preferred account such as an HSA. The amendment was withdrawn.

Congresswoman Judy Chu (D-CA) offered an amendment that would require the GOP health care bill to protect coverage for abortion. This bill would create sweeping new restrictions on abortion coverage for women who purchase health insurance using their own money. The restrictions in this bill have no meaningful exceptions to protect women's safety, and only create exceptions for the life of the mother, or for rape and incest, ignoring situations when the health of the mother is at risk or serious complications would result from the pregnancy. The amendment was defeated.

Democrats expressed concern that the Republican legislation could jeopardize access to community providers and interfere with patients getting access to the providers that they prefer to see. Congressman Davis offered an amendment to require that for an insurance plan to be tax credit eligible it must include as participating providers essential community providers. The Republicans' health plan does not guarantee access to local community health centers and essential local providers. Republicans want to let insurance companies go back to the days when they could cut out local community health centers and local doctors, and force Americans to drive for hours to find care. Not only will this make it hard for Americans to get the check-ups, vaccines, and prescriptions for antibiotics, insulin, and heart medications that they need, but it will make it hard for local providers who need paying customers to keep their doors open. The amendment would require that any tax credit only go to insurance plans that cover local community health centers and family physicians, rural providers, and other essential community providers.

Democrats expressed concern that the Republican reconciliation package would make it more difficult for small businesses to offer health coverage to their employees. The reconciliation package repeals the tax credit small businesses can receive under current law that is making health insurance coverage more affordable. Congresswoman DelBene offered an amendment that would reinstate the small business health tax credit program and make improvements that make it easier for small businesses to participate. More than half (55 percent) of all jobs are through small businesses. Since the 1970s, about two-thirds of net new jobs have been from small businesses. Helping support small businesses that choose to offer health coverage can help those businesses offer better paying jobs, and provide benefits to their employees.

Congresswoman Sanchez (D-CA) offered an amendment that would prohibit insurance companies from discriminating against women in pricing. The ACA has dramatically increased coverage for women, while also improving the accessibility, affordability, and quality of care. Prior to the passage of the ACA, women were charged significantly higher premiums if they were able to obtain coverage, and often lacked access to critical preventive care and maternity care services.¹⁹ The ACA ended these discriminatory practices, and as a result, millions of women now have access to affordable health coverage for the first time. Since the implementa-

¹⁹ <http://go.nationalpartnership.org/site/DocServer/SUMMARY.pdf?docID=1000>

tion of the ACA, 9.5 million women that were previously uninsured have gained affordable, comprehensive health coverage.²⁰ The uninsured rate among women ages 18 to 64 has decreased from 19.3 percent in 2010 to 10.8 percent in 2015.²¹

This amendment was based on the bipartisan Gender Equity in Health Premiums Act introduced by Congresswoman Sanchez and former Republican from Florida, Ginny Brown-Waite, which prohibited health insurance companies from engaging in “gender rating.” Gender rating is the practice of charging women more for health insurance premiums than men. This practice was prohibited as a result of the ACA. Under the Republican legislation, women have the most to lose. Congresswoman Ginny Brown-Waite said in 2009, “It is ludicrous that in this day and age, insurance companies can charge women more simply for being women. That is the definition of discrimination and it must end.” The motion to table the amendment was approved 23–16.

Congresswoman Chu (D–CA) offered an amendment that would ensure that the Republican legislation did not disadvantage minority health care. Specifically, the amendment would ensure that if the National Academies of Science determine that uninsured rates of minority communities would increase under this bill, then the bill will not take effect. There were significant decreases in the percentage of uninsured adults between 2013, before the ACA was implemented, and 2016 for Hispanic, non-Hispanic black, non-Hispanic white, and non-Hispanic Asian adults.²² Hispanic adults had the greatest percentage point decrease (15.9 percentage points) in the uninsured rate between 2013 and 2016.²³ The coverage gained by low income individuals because of the ACA halted the decades-long widening of the coverage gap between the rich and poor at a time when other disparities between rich and poor are growing.²⁴

Despite coverage gains from the ACA, data show that Asians, Hispanics, Blacks, and American Indians and Alaska Natives continue to face significant disparities in access to and utilization of care, health status and health outcomes, and health coverage.²⁵ However, the scope and types of disparities vary across racial and ethnic groups. The Republican legislation would likely harm the coverage gains made as a result of the ACA and increase barriers to care. The motion to table the amendment was approved 23–16.

After 18 hours of debate, at almost 4:00 a.m., Congressman Lewis offered an amendment to strike the Republican repeal and replace reconciliation package and establish a set of principles to develop legislation that would not harm the American people. Congressman Lewis stated that under the Republican legislation, “Tax cuts for the rich, wealthy, and corporations are the priority. The sick, the elderly, the middle class, and working Americans are left out and left behind. The American people cannot—must not—bear the burden. This is not right; this is not just. You can do better;

²⁰ <https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf>

²¹ <https://aspe.hhs.gov/system/files/pdf/205066/ACAWomenHealthIssueBrief.pdf>

²² <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201702.pdf>

²³ <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201702.pdf>

²⁴ https://www.nytimes.com/2016/04/18/health/immigrants-the-poor-and-minorities-gain-sharply-under-health-act.html?_r=0

²⁵ <http://kff.org/disparities-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity/>

you must do better.” This final amendment highlighted that Committee Republicans had rejected every single Democratic attempt to protect and assist America’s seniors and people with disabilities and middle-class Americans who rely on employer-sponsored insurance, Medicare and Medicaid. The amendment set forth a set of principles where people take priority over the rich and corporations.

In conclusion, Democrats strongly oppose the Republicans’ package of reconciliation bills. These bills decimate health coverage for middle and lower income Americans to pay for nearly \$600 billion in tax giveaways to millionaires and corporations.

RICHARD E. NEAL,
Ranking Member.

COMMITTEE PRINT

Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy

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

SEC. __01. RECAPTURE EXCESS ADVANCE PAYMENTS OF PREMIUM TAX CREDITS.

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

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

SEC. __02. ADDITIONAL MODIFICATIONS TO PREMIUM TAX CREDIT.

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

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

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

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

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

“(ii) includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).”.

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

“(C) GRANDMOTHERED HEALTH PLAN.—

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

“(ii) CCHIO GUIDANCE DEFINED.—The term ‘CCHIO guidance’ means the letter issued by the Centers for

Medicare & Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the individual health insurance market, as subsequently extended and modified (including by a communication entitled ‘Insurance Standards Bulletin Series—INFORMATION—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).

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

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

“(D) CERTAIN RULES RELATED TO ABORTION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) OTHER CONFORMING AMENDMENTS.—

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

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

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

“(A) APPLICABLE PERCENTAGE.—

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

“In the case of household income (expressed as a percent of the poverty line) within the following income tier:	Up to Age 29		Age 30-39		Age 40-49		Age 50-59		Over Age 59	
	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %
Up to 133%	2	2	2	2	2	2	2	2	2	2
133%-150%	3	4	3	4	3	4	3	4	3	4
150%-200%	4	4.3	4	5.3	4	6.3	4	7.3	4	8.3
200%-250%	4.3	4.3	5.3	5.9	6.3	8.05	7.3	9	8.3	10
250%-300%	4.3	4.3	5.9	5.9	8.05	8.35	9	10.5	10	11.5
300%-400%	4.3	4.3	5.9	5.9	8.35	8.35	10.5	10.5	11.5	11.5

“(ii) AGE DETERMINATIONS.—

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

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

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

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

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

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

(b) EFFECTIVE DATE.—

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

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

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

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

SEC. 03. PREMIUM TAX CREDIT.

(a) REPEAL OF PREMIUM TAX CREDIT.—Section 36B of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

“(h) TERMINATION.—No credit shall be allowed under this section with respect to any coverage month which begins after December 31, 2019.”.

(b) REPEAL OF ADVANCE PAYMENT OF, AND ELIGIBILITY DETERMINATION FOR, PREMIUM TAX CREDIT.—Section 1412 of the Patient Protection and Affordable Care Act, as amended by the preceding

provisions of this subtitle, is amended by adding at the end the following new subsection:

“(g) **TERMINATION WITH RESPECT TO PREMIUM TAX CREDIT.**—Effective January 1, 2020, no provision of this section or section 1411 shall apply to the credit allowed under section 36B of the Internal Revenue Code of 1986 (or to the advance payment of, or determination of eligibility for, such credit or payment).”.

(c) **EFFECTIVE DATES.**—

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

(2) **ELIGIBILITY DETERMINATIONS.**—The amendment made by subsection (b) shall take effect on January 1, 2020.

SEC. 404. SMALL BUSINESS TAX CREDIT.

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

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

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

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

“(1) **IN GENERAL.**—Any term”; and

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

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

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

“(B) **CERTAIN RULES RELATED TO ABORTION.**—

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

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

“(iii) **OTHER TREATMENTS.**—The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an

abortion shall not be treated as an abortion for purposes of subparagraph (A).”.

(c) **EFFECTIVE DATES.**—

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

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

SEC. 05. 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. 06. EMPLOYER MANDATE.

(a) **IN GENERAL.**—

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

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

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

SEC. 07. REPEAL OF THE TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS.

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

“(h) **SHALL NOT APPLY.**—No tax shall be imposed under this section with respect to any taxable period beginning after December 31, 2019, and before January 1, 2025.”.

SEC. 08. REPEAL OF TAX ON OVER-THE-COUNTER MEDICATIONS.

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

(b) **ARCHER MSAS.**—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by striking “Such term” and all that follows through the period.

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

(d) **EFFECTIVE DATES.**—

(1) **DISTRIBUTIONS FROM SAVINGS ACCOUNTS.**—The amendments made by subsections (a) and (b) shall apply to amounts

paid with respect to taxable years beginning after December 31, 2017.

(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2017.

SEC. 09. 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, 2017.

SEC. 10. 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, 2017.

SEC. 11. REPEAL OF MEDICAL DEVICE EXCISE TAX.

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

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

SEC. 12. 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, 2017.

SEC. 13. REPEAL OF INCREASE IN INCOME THRESHOLD FOR DETERMINING MEDICAL CARE DEDUCTION.

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

(b) EXTENSION OF SPECIAL RULE.—Subsection (f) of section 213 of such Code is amended—

(1) by striking “2017” and inserting “2018”, and

(2) by striking “AND 2016” and inserting “2016, AND 2017”.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2017.

(2) EXTENSION OF SPECIAL RULE.—The amendments made by subsection (b) shall apply to taxable years beginning after December 31, 2016.

SEC. 14. 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, 2017.

SEC. 15. 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 sum of the monthly credit amounts with respect to such taxpayer for calendar months during such taxable year.

“(b) **MONTHLY CREDIT AMOUNTS.**—

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

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

“(B) the amount paid for eligible health insurance for the taxpayer and the taxpayer’s qualifying family members for such month.

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

“(c) **MONTHLY LIMITATION AMOUNTS.**—

“(1) **IN GENERAL.**—The monthly limitation amount with respect to any individual for any eligible coverage month during any taxable year is $\frac{1}{12}$ of—

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

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

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

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

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

“(2) LIMITATION BASED ON MODIFIED ADJUSTED GROSS INCOME.—

“(A) IN GENERAL.—The amount otherwise determined under subsection (b)(1)(A) (without regard to this subparagraph but after any other adjustment of such amount under this section) for the taxable year shall be reduced (but not below zero) by 10 percent of the excess (if any) of—

“(i) the taxpayer’s modified adjusted gross income for such taxable year, over

“(ii) \$75,000 (twice such amount in the case of a joint return).

“(B) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this paragraph, the term ‘modified adjusted gross income’ means adjusted gross income increased by—

“(i) any amount excluded from gross income under section 911,

“(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax, and

“(iii) an amount equal to the portion of the taxpayer’s social security benefits (as defined in section 86(d)) which is not included in gross income under section 86 for the taxable year.

“(3) OTHER LIMITATIONS.—

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

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

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

“(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.

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

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

“(2) any dependent of the taxpayer, and

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

“(f) ELIGIBLE HEALTH INSURANCE.—For purposes of this section—

“(1) IN GENERAL.—The term ‘eligible health insurance’ means any health insurance coverage (as defined in section 9832(b)) if—

“(A) such coverage is either—

“(i) offered in the individual health insurance market within a State, or

“(ii) is unsubsidized COBRA continuation coverage,

“(B) such coverage is not a grandfathered health plan (as defined in section 1251 of the Patient Protection and Affordable Care Act) or a grandmothered health plan,

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

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

“(E) such coverage does not consist of short-term limited duration insurance (as defined by the Secretary), and

“(F) the State in which such insurance is offered certifies that such coverage meets the requirements of this paragraph.

“(2) RULES RELATED TO STATE CERTIFICATION.—

“(A) CERTIFICATION MADE AVAILABLE TO PUBLIC.—A certification shall not be taken into account under paragraph (1)(E) unless such certification is made available to the public and meets such other requirements as the Secretary may provide.

“(B) SPECIAL RULE FOR UNSUBSIDIZED COBRA CONTINUATION COVERAGE.—In the case of unsubsidized COBRA continuation coverage—

“(i) paragraph (1)(E) shall be applied by substituting ‘the plan administrator (as defined in section 414(g)) of the health plan’ for ‘the State in which such insurance is offered’, and

“(ii) the requirements of subparagraph (A) shall be treated as satisfied if the certification meets such requirements as the Secretary may provide.

“(3) GRANDMOTHERED HEALTH PLAN.—

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

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

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

“(g) 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—

“(i) coverage under a plan substantially all of the coverage of which is of excepted benefits described in section 9832(c), and

“(ii) COBRA continuation coverage.

“(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).

“(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.

“(h) UNSUBSIDIZED COBRA CONTINUATION COVERAGE.—For purposes of this section—

“(1) IN GENERAL.—The term ‘unsubsidized COBRA continuation coverage’ means COBRA continuation coverage no portion of the premiums for which are subsidized by the employer.

“(2) 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.

“(i) 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.—

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

“(B) COORDINATION WITH RULE FOR OLDER CHILDREN.—In the case of any individual who is a qualifying family member described in subsection (e)(3) with respect to another taxpayer for any month, in determining the amount of any credit allowable to such individual under this section for any taxable year of such individual which includes such month, the monthly limitation amount with respect to such individual for such month shall be zero and no amount paid for eligible health insurance with respect to such individual for such month shall be taken into account.

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

“(4) 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 sum determined under subsection (b)(1)(A) with respect to the taxpayer for such month shall be reduced (but not below zero) by $\frac{1}{12}$ 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) CERTAIN RULES RELATED TO ABORTION.—

“(A) OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.—Nothing in subsection (f)(1)(D) 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 (f)(1)(D) shall restrict any 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.

“(C) OTHER TREATMENTS.—The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion shall not be treated as an abortion for purposes of subsection (f)(1)(D).

“(8) INFLATION ADJUSTMENT.—

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

subsection (c)(1), the \$75,000 amount in subsection (c)(2)(A)(ii), and the dollar amount in subsection (c)(3)(A), shall be increased by an amount equal to—

“(i) such dollar amount, multiplied by

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

“(I) by substituting ‘calendar year 2019’ for ‘calendar year 1992’ in subparagraph (B) thereof, and

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

“(B) TERMS RELATED TO CPI.—

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

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

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

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

(b) **ADVANCE PAYMENT OF CREDIT; EXCESS HEALTH INSURANCE COVERAGE CREDIT PAYABLE TO HEALTH SAVINGS ACCOUNT.**—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 (hereafter in this section referred to as the ‘advance payment 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.**—

“(1) **IN GENERAL.**—The advance payment program 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 (determined without regard to section 1412(f) of such Act) and each entity that is authorized to take any actions under the programs created under such sections (as so determined)

shall, at the request of the Secretary, take such actions to the extent necessary to carry out this section.

“(2) APPLICATION TO OFF-EXCHANGE COVERAGE.—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, the sections referred to in paragraph (1) shall be applied by treating references in such sections to an Exchange as references to the provider of such eligible health insurance (or, as the Secretary determines appropriate, to the licensed agent or broker with respect to such insurance), except that the Secretary of Health and Human Services shall carry out the responsibilities of the Exchange under section 1411(e)(4) of the Patient Protection and Affordable Care Act (determined without regard to section 1412(f) of such Act) in the case of such insurance.

“(3) DOCUMENTATION REGARDING OTHER SPECIFIED COVERAGE.—

“(A) IN GENERAL.—The advance payment program shall provide that any individual applying to have payments made on their behalf under such program shall, if such individual (or any qualifying family member of such individual taken into account in determining the amount of the credit allowable under section 36C) is employed, submit a written statement from each employer of such individual or such qualifying family member stating whether such individual or qualifying family member (as the case may be) is eligible for other specified coverage in connection with such employment.

“(B) ISSUANCE OF STATEMENTS.—An employer shall, at the request of any employee, provide the statement under subparagraph (A) at such time, and in such form and manner, as the Secretary may provide.

“(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 subparagraph (A) of section 36C(b)(1) exceeds the amount described in subparagraph (B) 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(e)) 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 (c)(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 sections 7529 and 36C(i)(5)(B).”.

(c) INFORMATION REPORTING.—

(1) REPORTING BY HEALTH INSURANCE PROVIDERS.—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 BY HEALTH INSURANCE PROVIDERS 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 reporting under subsection (b) shall 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,

“(E) whether such policy constitutes a high deductible health plan (as defined in section 223(c)(2)), and

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

“(16) each month with respect to which the employee is eligible for other specified coverage (as defined in section 36C(g)) in connection with employment with the employer.”.

(3) 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 a comma, and by adding after subparagraph (II) the following new subparagraphs:

“(JJ) section 6050X (relating to returns relating to health insurance coverage credit), or

“(KK) section 7529(c)(3) (relating to documentation regarding other specified coverage).”.

(d) DISCLOSURES.—Paragraph (21) of section 6103(l) of the Internal Revenue Code of 1986 is amended—

(1) in subparagraph (A)—

(A) by striking “any premium tax credit under section 36B or any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act or” and inserting “any credit under section 36C”,

(B) by striking “, a State’s children’s health insurance program under title XXI of the Social Security Act, or a basic health program under section 1331 of Patient Protection and Affordable Care Act” and inserting “or a State’s children’s health insurance program under title XXI of the Social Security Act”,

(C) by striking “(as defined in section 36B)” in clause (iv) and inserting “(as defined in section 36C(c)(2)(B))”, and

(D) by striking “or reduction” in clause (v),

(2) in subparagraph (B)—

(A) by striking “may disclose to an Exchange” and inserting “may disclose—

“(i) to an Exchange”, and

(B) by striking the period at the end and inserting “, and”, and

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

“(ii) in the case of any credit under section 36C with respect to any health insurance, the amount of such credit (or the amount of any advance payment of such credit) to the provider of such insurance (or, as the Secretary determines appropriate, the licensed agent or broker with respect to such insurance).”, and

(3) in subparagraph (C)(i), by striking “amount of, any credit or reduction” and inserting “amount of any credit”.

(e) INCREASED PENALTY ON ERRONEOUS CLAIMS OF CREDIT.—Section 6676(a) of such Code is amended by inserting “(25 percent in the case of a claim for refund or credit relating to the health insurance coverage credit under section 36C)” after “20 percent”.

(f) CONFORMING AMENDMENTS.—

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

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

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

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

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

“(I) the sum of any advance payments made on behalf of the taxpayer under 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 (i)(5)(A) thereof) for such taxable year, and

“(ii) section 36C(i)(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 (i)(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 by health insurance providers 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 items:

“Sec. 7529. Advance payment of health insurance coverage credit.

“Sec. 7530. Excess health insurance coverage credit payable to health savings account.”.

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

SEC. 16. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAVINGS ACCOUNT INCREASED TO AMOUNT OF DEDUCTIBLE AND OUT-OF-POCKET LIMITATION.

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

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

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

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

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

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

SEC. 17. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CONTRIBUTIONS TO THE SAME HEALTH SAVINGS ACCOUNT.

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

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

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

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

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

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

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

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

SEC. 18. 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.

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SUBTITLE [B]—REPEAL OF CERTAIN CONSUMER TAXES

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

In fulfillment of the reconciliation instructions included in section 2002 of the Concurrent Resolution on the Budget for Fiscal Year 2017 (S. Con. Res. 3), the Committee on Ways and Means ordered favorably transmitted (with a quorum being present) the Budget Reconciliation Legislative Recommendations Relating to Repeal of Certain Consumer Taxes. The Committee recommends repeal of the tax on branded prescription pharmaceutical manufacturers and importers and the health insurance provider tax imposed by the Patient Protection and Affordable Care Act of 2010 (“PPACA”), Pub. L. No. 111–148 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (“HCERA”), Pub. L. No. 111–152 (March 30, 2010).¹

B. BACKGROUND AND NEED FOR LEGISLATION

In the Committee’s pursuit of comprehensive health care reform to relieve unnecessary burdens on insurance markets, the broader economy, and taxpayers in need of access to quality health care, the Committee wishes to provide relief from taxes imposing excessive constraints on choice and innovation. The Committee believes that repeal of the tax on branded prescription pharmaceutical manufacturers and importers and the health insurance provider tax will further these goals.

C. LEGISLATIVE HISTORY

Budget resolution

On January 13, 2017, the House of Representatives approved S. Con. Res. 3, the budget resolution for fiscal year 2017. Pursuant to section 2002(a)(3) of S. Con. Res. 3, the Committee on Ways and Means was directed to submit to the Committee on the Budget recommendations for changes in law within the jurisdiction of the Committee on Ways and Means sufficient to reduce the deficit by \$1,000,000,000 for the period of fiscal years 2017 through 2026.

Committee action

Beginning on March 8, 2017, in response to its instructions under the budget resolution, the Committee on Ways and Means marked up the budget reconciliation legislative recommendations relating to repeal of the tax on branded prescription pharmaceutical manufacturers and importers and the health insurance provider tax and ordered the legislative recommendations, as amended, favorably transmitted (with a quorum being present) on March 9, 2017.

Committee hearings

The Committee on Ways and Means held hearings regarding the President’s Fiscal Year 2017 budget submission on February 11,

¹ PPACA and HCERA are collectively referred to as the Affordable Care Act (“ACA”).

2016, and February 10, 2016 with Secretary of the Treasury Jacob J. Lew and Secretary of Health and Human Services Sylvia Burwell, respectively, in which the harmful effects of ACA taxes were discussed. Moreover, the Oversight Subcommittee held a hearing on March 5, 2013, discussing the tax-related provisions of the ACA.

II. EXPLANATION OF PROVISIONS

A. REPEAL OF ANNUAL FEE ON BRANDED PRESCRIPTION PHARMACEUTICAL MANUFACTURERS AND IMPORTERS (SEC. __01 of the committee print and sec. 9008 of PPACA)

PRESENT LAW

An annual fee is imposed on covered entities engaged in the business of manufacturing or importing branded prescription drugs for sale to any specified government program or pursuant to coverage under any such program.² Fees collected are credited to the Medicare Part B trust fund.

The aggregate annual fee imposed on all covered entities is \$4 billion for calendar year 2017, \$4.1 billion for calendar year 2018, and \$2.8 billion for calendar year 2019 and thereafter. The aggregate fee is apportioned among the covered entities each year based on their relative share of branded prescription drug sales taken into account during the previous calendar year.

A covered entity's relative market share for a calendar year is the entity's branded prescription drug sales taken into account during the preceding calendar year as a percentage of the aggregate branded prescription drug sales of all covered entities taken into account during the preceding calendar year. Sales taken into account during any calendar year with respect to a covered entity are: (1) zero percent of sales not more than \$5 million; (2) 10 percent of sales over \$5 million but not more than \$125 million; (3) 40 percent of sales over \$125 million but not more than \$225 million; (4) 75 percent of sales over \$225 million but not more than \$400 million; and (5) 100 percent of sales over \$400 million.

A covered entity is any manufacturer or importer with gross receipts from branded prescription drug sales. All persons treated as a single employer under section 52(a) or (b) or under section 414(m) or (o) are treated as a single covered entity. In applying the single employer rules under 52(a) and (b), foreign corporations are not excluded. If more than one person is liable for payment of the fee, all such persons are jointly and severally liable for payment of such fee.

Branded prescription drug sales are sales of branded prescription drugs made to any specified government program, or pursuant to coverage under any such program. The term branded prescription drugs includes any drug which is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act and for which an application was submitted under section 351(a) of such Act. Branded prescription drug sales do not include sales of any drug or biological product with respect to which an orphan drug tax credit was allowed

²Sec. 9008 of PPACA, as amended.

for any taxable year under section 45C. The exclusion for orphan drug sales does not apply to any drug or biological product after such drug or biological product is approved by the Food and Drug Administration for marketing for any indication other than the rare disease or condition with respect to which the section 45C credit was allowed.

Specified government programs include: (1) the Medicare Part D program under part D of title XVIII of the Social Security Act; (2) the Medicare Part B program under part B of title XVIII of the Social Security Act; (3) the Medicaid program under title XIX of the Social Security Act; (4) any program under which branded prescription drugs are procured by the Department of Veterans Affairs; (5) any program under which branded prescription drugs are procured by the Department of Defense; or (6) the TRICARE retail pharmacy program under section 1074g of title 10, United States Code.

The fees are treated in the same manner as those excise taxes identified in subtitle F, "Procedure and Administration" for which the only avenue for judicial review is a civil action for refund. Thus, the fees may be assessed and collected using the procedures in subtitle F without regard to the restrictions on assessment in section 6213.

The fee is required to be paid no later than an annual payment date determined by the Secretary of the Treasury, but in no event later than September 30th each calendar year.

For purposes of section 275, relating to the nondeductibility of specified taxes, the fee is considered to be a nondeductible tax described in section 275(a)(6).

REASONS FOR CHANGE

The U.S. pharmaceutical industry is a leader in innovation. The industry is an important contributor to the nation's economy, employing thousands of people and manufacturing pharmaceutical drugs both for the U.S. and foreign markets. The Committee believes that the annual fee on branded prescription pharmaceutical manufacturers and importers adversely affects the industry. The Committee believes that repealing the annual fee on branded prescription pharmaceutical manufacturers and importers will decrease the cost of healthcare.

EXPLANATION OF PROVISION

Under the provision, the annual fee on branded prescription pharmaceutical manufacturers and importers applies for calendar years ending before 2018. Thus, the annual fee does not apply for any calendar year beginning after 2017.

EFFECTIVE DATE

The provision is effective upon enactment.

B. REPEAL OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS (SEC. ___02 of the committee print and sec. 9010 of PPACA)

PRESENT LAW

An annual fee applies to any covered entity engaged in the business of providing health insurance with respect to United States (“U.S.”) health risks.³ The aggregate annual fee for all covered entities is the applicable amount. The applicable amount is \$8 billion for calendar year 2014, \$11.3 billion for calendar years 2015 and 2016, \$13.9 billion for calendar year 2017, and \$14.3 billion for calendar year 2018. However, a one-year moratorium applies to the annual fee on health insurance providers for calendar year 2017. For calendar years after 2018, the applicable amount is indexed to the rate of premium growth.

The aggregate annual fee is apportioned among the providers based on a ratio designed to reflect relative market share of U.S. health insurance business. For each covered entity, the fee for a calendar year is an amount that bears the same ratio to the applicable amount as (1) the covered entity’s net premiums written during the preceding calendar year with respect to health insurance for any U.S. health risk, bears to (2) the aggregate net written premiums of all covered entities during such preceding calendar year with respect to such health insurance.

REASONS FOR CHANGE

The Committee understands that the annual fee on health insurance providers is passed through to a large extent by insurers to consumers in the form of higher health insurance premiums. Consumers may bear this burden by paying a higher price for the breadth of health coverage they would prefer, or by selecting more restricted health coverage for a lower price. The Committee believes that health insurance premiums will be reduced in the absence of the health insurer fee, and therefore, the bill terminates the annual fee on health insurance providers.

EXPLANATION OF PROVISION

Under the provision, the annual fee on health insurance providers applies only for calendar years beginning after 2013 and before 2017. Thus, the annual fee does not apply for any calendar year beginning after 2016.

EFFECTIVE DATE

The provision is effective upon enactment.

³Sec. 9010 of PPACA.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of the Reconciliation Legislative Recommendations Relating to Repeal of Certain Consumer Taxes on March 8, 2017.

The vote on the amendment by Mr. Blumenauer to the amendment in the nature of a substitute to Subtitle ____: Budget Reconciliation Legislative Recommendations Relating to Repeal of Certain Consumer Taxes, which would strike the repeal of the pharmaceutical company fee and transfer the revenues to the Federal Supplemental Medical Insurance trust fund, was not agreed to by a roll call vote of 24 yeas to 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady		X	.....	Mr. Neal	X	.....	.....
Mr. Johnson		X	.....	Mr. Levin	X	.....	.....
Mr. Nunes		X	.....	Mr. Lewis	X	.....	.....
Mr. Tiberi		X	.....	Mr. Doggett	X	.....	.....
Mr. Reichert		X	.....	Mr. Thompson	X	.....	.....
Mr. Roskam		X	.....	Mr. Larson	X	.....	.....
Mr. Buchanan		X	.....	Mr. Blumenauer	X	.....	.....
Mr. Smith (NE)		X	.....	Mr. Kind	X	.....	.....
Ms. Jenkins		X	.....	Mr. Pascrell	X	.....	.....
Mr. Paulsen		X	.....	Mr. Crowley	X	.....	.....
Mr. Marchant		X	.....	Mr. Davis	X	.....	.....
Ms. Black		X	.....	Ms. Sanchez	X	.....	.....
Mr. Reed		X	.....	Mr. Higgins	X	.....	.....
Mr. Kelly		X	.....	Ms. Sewell	X	.....	.....
Mr. Renacci		X	.....	Ms. DelBene	X	.....	.....
Mr. Meehan		X	.....	Ms. Chu	X	.....	.....
Ms. Noem		X	.....			
Mr. Holding		X	.....			
Mr. Smith (MO)		X	.....			
Mr. Rice		X	.....			
Mr. Schweikert		X	.....			
Ms. Walorski		X	.....			
Mr. Curbelo		X	.....			
Mr. Bishop		X	.....			

Mr. Reichert's motion to table Ms. DelBene's appeal of the ruling of the Chair was agreed to by a roll call vote of 24 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins	X	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sanchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

The legislation was ordered favorably transmitted to the House Committee on the Budget as amended by a roll call vote of 24 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins	X	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sanchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

IV. BUDGET EFFECTS OF THE PROVISIONS

A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the “Budget Reconciliation Legislative Recommendations Relating to Repeal of Certain Consumer Taxes.”

The budget reconciliation legislative recommendations, as transmitted, are estimated to have the following effects on budget receipts for fiscal years 2017–2026:

Pursuant to clause 8 of rule XIII of the Rules of the House of Representatives, the following statement is made by the Joint Committee on Taxation with respect to the provisions of the budget reconciliation legislative recommendation amending the Internal Revenue Code of 1986: the gross budgetary effect (before incorporating macroeconomic effects) in any fiscal year is less than 0.25 percent of the current projected gross domestic product of the United States for that fiscal year; therefore, the bill is not “major legislation” for purposes of requiring that the estimate include the budgetary effects of changes in economic output, employment, capital stock and other macroeconomic variables.

**B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX
EXPENDITURES BUDGET AUTHORITY**

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the budget reconciliation legislative recommendations involve no new or increased budget authority. The Committee states further that the budget reconciliation legislative recommendations involve no new or increased tax expenditures.

**C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET
OFFICE**

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, refer to Subtitle E.

**V. OTHER MATTERS TO BE DISCUSSED UNDER THE
RULES OF THE HOUSE**

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee advises that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated into the description portions of this report.

B. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the budget reconciliation legislative recommendations contain no measures that authorize funding, so no statement of general performance goals and objectives for which any measure authorizing funding is required.

C. INFORMATION RELATING TO UNFUNDED MANDATES

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104-4).

The Committee has determined that the budget reconciliation legislative recommendations do not contain any private sector mandates. The Committee has determined that the budget reconcili-

ation legislative recommendations do not impose any Federal inter-governmental mandates on State, local, or tribal governments.

D. APPLICABILITY OF HOUSE RULE XXI 5(b)

Rule XXI 5(b) of the Rules of the House of Representatives provides, in part, that “A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting, a quorum being present.” The Committee has carefully reviewed the provisions of the budget reconciliation legislative recommendations and states that the provisions of the legislative recommendations do not involve any Federal income tax rate increases within the meaning of the rule.

E. TAX COMPLEXITY ANALYSIS

Section 4022(b) of the Internal Revenue Service Restructuring and Reform Act of 1998 (“IRS Reform Act”) requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses.

Pursuant to clause 3(h)(1) of rule XIII of the Rules of the House of Representatives, the staff of the Joint Committee on Taxation has determined that a complexity analysis is not required under section 4022(b) of the IRS Reform Act because the budget reconciliation legislative recommendations contain no provisions that amend the Code and that have “widespread applicability” to individuals or small businesses, within the meaning of the rule.

F. CONGRESSIONAL EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the budget reconciliation legislative recommendations and states that the provisions of the legislative recommendations do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

G. DUPLICATION OF FEDERAL PROGRAMS

In compliance with clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee states that the budget reconciliation legislative recommendations do not establish or reauthorize: (1) a program of the Federal Government known to be duplicative of another Federal program, (2) a program included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or (3) a program related to a program identified in the most recent Catalog of Federal Do-

mestic Assistance, published pursuant to section 6104 of title 31, United States Code.

H. DISCLOSURE OF DIRECTED RULE MAKINGS

In compliance with Sec. 3(i) of H. Res. 5 (115th Congress), the following statement is made concerning directed rule makings: The Committee advises that the budget reconciliation legislative recommendations require no directed rule makings within the meaning of such section.

VI. CHANGES IN EXISTING LAW MADE BY THE BUDGET RECONCILIATION LEGISLATIVE RECOMMENDATIONS, AS TRANSMITTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes to existing law made by the recommendations, as transmitted, are shown in subtitle E of title II.

VII. DISSENTING VIEWS

DISSENTING VIEWS ON RECOMMENDATION TO REPEAL THE HEALTH INSURANCE FEE AND PHARMACEUTICAL FEE, COMMITTEE PRINT 3

1. Donald Trump promised that “we’re going to have insurance for everybody . . . [but it will be] much less expensive and much better.” This bill reveals those promises for what they always were: empty campaign rhetoric.”—Families USA¹

2. “We cannot support the AHCA as drafted because of the expected decline in health insurance coverage and the potential harm it would cause to vulnerable patient populations.”—American Medical Association²

3. “Repeal-and-replace is a gigantic transfer of wealth from the lowest-income Americans to the highest-income Americans.”—Edward D. Kleinbard, former chief of staff for the Joint Committee on Taxation and professor, University of Southern California School of Law.³

The five reconciliation legislative recommendations considered by the Committee on Ways and Means (the “Committee”) and referred to the Committee on Budget (collectively, the Ways and Means reconciliation package or the “reconciliation package”) was a far-reaching attempt to undermine our health systems from Medicare to employer sponsored health insurance in order to give tax cuts to the wealthiest and corporations. After almost 18 hours of debate, the Committee mark-up ended with a party-line vote on the reconciliation package, which is likely to take health insurance away from millions of Americans. This reconciliation package, coupled with what was passed out of the Energy and Commerce Committee, would harm access to health care for middle-class Americans and undermine Medicare’s long-term viability while cutting taxes for corporations and the wealthiest Americans.

The Committee moved forward irresponsibly, without any official accounting about the estimated effect of the reconciliation package on health insurance coverage, out-of-pocket costs, or premium increases. While the Joint Committee on Taxation (JCT) estimated that the reconciliation package includes nearly \$600 billion worth of tax breaks, as of the mark-up, the Congressional Budget Office (CBO) was unable to provide estimates about the package’s effect on American families. Additionally the JCT score was incomplete as of the mark-up and did not provide an official accounting of all of the provisions considered by the Committee. Both the Ways and Means and Energy and Commerce Committees moved forward to

¹ <http://familiesusa.org/blog/2017/03/healthy-and-wealthy-benefit-under-house-republican-affordable-care-act-repeal-plan>.

² <https://www.ama-assn.org/sites/default/files/media-browser/public/washington/ama-letter-on-ahca.pdf>.

³ https://www.nytimes.com/2017/03/10/business/tax-cuts-affordable-care-act-repeal.html?_r=1.

pass recommendations out of each Committee without any sense from CBO of coverage losses due to the severe cuts to Medicaid, the repeal of the individual and employer-shared responsibility provisions of current law, or the changes in the tax credits available to help purchase health insurance on the individual market.

CBO provided the Committee an estimate of the effects after the reconciliation package was reported to the Committee on Budget from the Ways and Means and Energy and Commerce Committees. This estimate showed that 24 million Americans would lose coverage, with 14 million Americans losing coverage in the first year alone.

The Committee's reconciliation package provided generous tax cuts to the wealthiest, while reducing health insurance assistance for middle-class Americans. The tax breaks considered by the Committee are focused on the wealthy individuals and corporations, instead on middle-class Americans. About \$275 billion in tax breaks would benefit high-income earners; about 62% of the tax breaks would go to millionaires in 2020. Businesses and corporations are receive nearly \$192 billion in tax cuts. These and other tax breaks add up to nearly \$600 billion in lost revenue.

Democrats objected strenuously to the Republican approach and instead believe the Committee should focus on policies that matter to middle-class Americans under the jurisdiction of this Committee, including financing long-term infrastructure, reforming the tax system to address income inequality, and further building on President Obama's record of job creation. Democrats believe that the reconciliation package will destabilize the health insurance market, which represents 18 percent of our gross domestic product.

The reconciliation package continues Republican efforts to undermine and destabilize the health insurance market. It undermines current law and the stability of both the individual and group health insurance markets by gutting individual and employer-shared responsibility provisions. The reconciliation package would reduce the uptake of the premium tax credits and the Medicaid expansion established in the Affordable Care Act (ACA), which have made health care affordable for millions of individuals. Reduced uptake of the Medicaid expansion and the tax credits disproportionately impacts low- and middle-income Americans and places them at risk for health insecurity and unexpected medical expenses. Based on independent estimates, roughly 24 million Americans would lose their insurance coverage because of this reconciliation package when taken together with the reconciliation recommendations passed by the Energy and Commerce Committee.⁴ Further, this reconciliation package reduces the life of the Medicare Trust Fund by three years by reducing \$170 billion from the Medicare Trust Fund, which puts Medicare at risk for 57 million seniors and individuals with disabilities.

Individual and employer-shared responsibility provisions are key to maintaining the robust and healthy risk pools that allow the ACA health insurance reforms to improve consumer protections while controlling health care costs. This is because well-functioning

⁴ <https://www.brookings.edu/blog/up-front/2017/03/09/expect-the-cbo-to-estimate-large-coverage-losses-from-the-gop-health-care-plan/>.

insurance markets rely on participation of both healthy and sick individuals to spread risk across the pool. The reconciliation package effectively would repeal the individual and employer-shared responsibility penalty, leading to premium increases of an estimated 20 percent in the individual market alone. In spite of President Trump and Congressional Republicans' efforts to sabotage the ACA, millions of Americans have enrolled in the health insurance Marketplaces, many using the available financial assistance, and millions more have enrolled in expanded Medicaid programs.

Despite promises made by President Trump, the reconciliation package would not cover more people or offer more affordable coverage with comparable benefits. Instead, this package leads to an estimated coverage loss of 24 million people while gutting benefits and consumer protections as a mechanism for affordability. When coupled with the legislation passed out of the Energy and Commerce Committee, the reconciliation package would return to a time when the market once again discriminates against those with pre-existing conditions and leaves those that might need medical care in the future without meaningful coverage. The reconciliation package provides for tax credits less generous than current law with no assistance with out-of-pocket expenses. Instead, the reconciliation package enshrines high deductible health plans that would increase out-of-pocket expenses. However, these plans do not address the underlying issues of access to quality services and the cost of care.

Since January of 2009, the Republicans voted to repeal or undermine the ACA more than 65 times. Democrats offered a number of amendments in Committee to point out serious flaws with the reconciliation package. For example, at the beginning of the mark up, Democrats asked Republicans to postpone mark up until CBO could provide a comprehensive report on costs, coverage losses, and premium effects of the reconciliation package.

In that regard, Congressman Lloyd Doggett (D-TX) offered a motion to postpone the markup for one week to allow time for review of the bill and the CBO estimate that was not available prior to or during the mark up. For over four decades, CBO has been recognized as the official referee of costs and effects of legislation passed in the House and Senate. Congress relies on CBO's non-partisan estimates to evaluate legislative proposals. Democrats were concerned that Republicans deliberately moved forward with the reconciliation package without a CBO score in an effort to conceal the harmful effects of the reconciliation package on nearly all Americans.

The contrast of this rushed process versus the lengthy and transparent process of enacting the ACA is striking. In 2009, House Committees posted a draft of the ACA legislation for review and comment a month before the mark-up process began, holding multiple hearings and providing the public with two preliminary CBO estimates on July 8th and July 14th. Democrats maintain that there is no reason to rush to mark-up this reconciliation package without a CBO score, or without a hearing to consider the implications of the package. Congressman Doggett's amendment was tabled on a party line vote.

This Committee print provided \$169.5 billion in tax breaks to prescription drug and insurance companies. At the same time, Republicans cut Medicaid by more than \$370 billion⁵ to help pay for this giveaway which would result in millions of low-income working families to lose their health insurance coverage, forcing them to rely on emergency room care that Americans all end up paying for in higher health insurance premiums.

Congressman Blumenauer (D-OR) offered an amendment to retain current law with respect to taxation of brand pharmaceutical companies and invest those tax revenues in lowering seniors' drug costs by filling the Medicare Part D donut hole. Medicare beneficiaries, even with Medicare Part D coverage, still struggle to pay for medications when they reach the coverage gap, known as the donut hole. While the ACA filled in part of this gap and saved America's seniors and people with disabilities an average of \$1,200 each year, it should remain a priority to continue to reduce the financial burdens for seniors and people with disabilities rather than providing pharmaceutical companies huge tax breaks. Democrats unanimously supported the amendment, but all Committee Republicans voted against improving drug coverage under Part D and lowering costs for seniors.

Congresswoman Suzan DelBene (D-WA) offered an amendment striking provisions that would restrict women's choice of health care providers. Her amendment sought to protect access to women's health care, including access to Planned Parenthood. Every year, 2.5 million people rely on Planned Parenthood health centers for essential health services, and studies consistently show that proposals to "defund" Planned Parenthood would result in people losing access to quality health care.⁶ The American Medical Association raised concerns with these provisions, saying, "The AMA cannot support provisions that prevent Americans from choosing to receive care from physicians and other qualified providers, in this specific case, those associated with Planned Parenthood affiliates, for otherwise covered services."⁷ Democrats unanimously supported the amendment, but all Committee Republicans voted against supporting women's access to health care services.

RICHARD E. NEAL,
Ranking Member.

⁵ "House GOP Medicaid Provisions Would Shift \$370 Billion in Costs To States," Center on Budget and Policy Priorities, March 7, 2017.

⁶ <http://www.cnn.com/2015/08/04/health/planned-parenthood-by-the-numbers/>.

⁷ <https://www.ama-assn.org/sites/default/files/media-browser/public/washington/ama-letter-on-ahca.pdf>.

COMMITTEE PRINT

Budget Reconciliation Legislative Recommendations Relating to Repeal of Certain Consumer Taxes

Subtitle _____—Repeal of Certain Consumer Taxes

SEC. _ 1. REPEAL OF TAX ON PRESCRIPTION MEDICATIONS.

Section 9008 of the Patient Protection and Affordable Care Act is amended by adding at the end the following new subsection:

“(l) TERMINATION.—No fee shall be imposed under subsection (a)(1) with respect to any calendar year beginning after December 31, 2017.”.

SEC. _ 2. REPEAL OF HEALTH INSURANCE TAX.

Section 9010 of the Patient Protection and Affordable Care Act is amended by adding at the end the following new subsection:

“(k) TERMINATION.—No fee shall be imposed under subsection (a)(1) with respect to any calendar year beginning after December 31, 2017.”.

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SUBTITLE C—REPEAL OF TANNING TAX

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

In fulfillment of the reconciliation instructions included in section 2002 of the Concurrent Resolution on the Budget for Fiscal Year 2017 (S. Con. Res. 3), the Committee on Ways and Means ordered favorably transmitted (with a quorum being present) the Budget Reconciliation Legislative Recommendations Relating to Repeal of Tanning Tax. The Committee recommends repeal of the indoor tanning tax imposed by the Patient Protection and Affordable Care Act of 2010 (“PPACA”), Pub. L. No. 111–148 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (“HCERA”), Pub. L. No. 111–152 (March 30, 2010).¹

B. BACKGROUND AND NEED FOR LEGISLATION

In the Committee’s pursuit of comprehensive health care reform to relieve unnecessary burdens on insurance markets, the broader economy, and taxpayers in need of access to quality health care, the Committee wishes to provide relief from taxes imposing excessive constraints on choice and innovation. The Committee believes that repeal of the indoor tanning tax will further these goals.

C. LEGISLATIVE HISTORY

Budget resolution

On January 13, 2017, the House of Representatives approved S. Con. Res. 3, the budget resolution for fiscal year 2017. Pursuant to section 2002(a)(3) of S. Con. Res. 3, the Committee on Ways and Means was directed to submit to the Committee on the Budget recommendations for changes in law within the jurisdiction of the Committee on Ways and Means sufficient to reduce the deficit by \$1,000,000,000 for the period of fiscal years 2017 through 2026.

Committee action

Beginning March 8, 2017, in response to its instructions under the budget resolution, the Committee on Ways and Means marked up the budget reconciliation legislative recommendations relating to repeal of the tanning tax and ordered the legislative recommendations, as amended, favorably transmitted (with a quorum being present) on March 9, 2017.

Committee hearings

The Committee on Ways and Means held hearings regarding the President’s Fiscal Year 2017 budget submission on February 11, 2016, and February 10, 2016 with Secretary of the Treasury Jacob J. Lew and Secretary of Health and Human Services Sylvia Burwell, respectively, in which the harmful effects of ACA taxes were discussed. Moreover, the Oversight Subcommittee held a

¹ PPACA and HCERA are collectively referred to as the Affordable Care Act (“ACA”).

hearing on March 5, 2013, discussing the tax-related provisions of the ACA.

II. EXPLANATION OF PROVISION

A. REPEAL OF TANNING TAX (SEC. 5000B OF THE CODE²)

PRESENT LAW

A retail sales tax is imposed on indoor tanning services.³ The tax rate is 10 percent of the amount paid for such services, including any amount paid by insurance.⁴ If a payment covers charges for indoor tanning services as well as other goods and services, the charges for other goods and services may be excluded in computing the tax payable on the amount paid.⁵

Consumers are liable for the tax, with service providers being responsible for collecting and remitting the tax to the Federal Government on a quarterly basis.

Indoor tanning services are services employing any electronic product designed to induce skin tanning and which incorporates one or more ultraviolet lamps with wavelengths in air between 200 and 400 nanometers.⁶ Taxable services do not include phototherapy services⁷ performed by a licensed medical professional. There is also an exemption for qualified physical fitness facilities that meet certain criteria and offer tanning as an incidental service to members without a separately identifiable fee.⁸

REASONS FOR CHANGE

The indoor tanning industry is an important contributor to the nation's economy, employing thousands of people. The Committee believes that the tanning tax adversely affects the industry. The Committee believes that repealing the tax will decrease costs for the industry and for consumers.

EXPLANATION OF PROVISION

Under the provision, the tax on indoor tanning services applies for services performed prior to January 1, 2018. Thus, the tax does not apply to services performed after December 31, 2017.

EFFECTIVE DATE

The provision is effective for services performed after December 31, 2017.

² All section references herein are to the Internal Revenue Code of 1986, as amended, ("Code") unless otherwise stated.

³ Sec. 5000B.

⁴ The total amount paid is presumed to include the tax if the tax is not separately stated. Treas. Reg. sec. 48.5000B-1(d)(1)(i).

⁵ Treas. Reg. sec. 48.5000B-1(c)(2), (d)(2), and (d)(3).

⁶ Treas. Reg. sec. 48.5000B-1(c)(1).

⁷ Phototherapy services are services that expose an individual to specific wavelengths of light for the treatment of (i) dermatological conditions, such as acne, psoriasis, and eczema; (ii) sleep disorders; (iii) seasonal affective disorder or other psychiatric disorder; (iv) neonatal jaundice; (v) wound healing; and (vi) other medical conditions determined by a licensed medical professional to be treatable by exposing the individual to specific wavelengths of light. Treas. Reg. sec. 48.5000B-1(c)(3).

⁸ Treas. Reg. sec. 48.5000B-1(d)(4).

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of the Reconciliation Legislative Recommendation Relating to Repeal of Tanning Tax on March 8, 2017.

The vote on the amendment by Ms. Sanchez to the amendment in the nature of a substitute to Subtitle __: Budget Reconciliation Legislative Recommendations Relating to Repeal of Tanning Tax, which would strike the repeal of the Tanning Tax and express the sense of Congress that the Tanning Tax should not be repealed, was not agreed to by a roll call vote of 24 yeas to 16 yeas (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady		X	.....	Mr. Neal	X	.....	.....
Mr. Johnson		X	.....	Mr. Levin	X	.....	.....
Mr. Nunes		X	.....	Mr. Lewis	X	.....	.....
Mr. Tiberi		X	.....	Mr. Doggett	X	.....	.....
Mr. Reichert		X	.....	Mr. Thompson	X	.....	.....
Mr. Roskam		X	.....	Mr. Larson	X	.....	.....
Mr. Buchanan		X	.....	Mr. Blumenauer	X	.....	.....
Mr. Smith (NE)		X	.....	Mr. Kind	X	.....	.....
Ms. Jenkins		X	.....	Mr. Pascrell	X	.....	.....
Mr. Paulsen		X	.....	Mr. Crowley	X	.....	.....
Mr. Marchant		X	.....	Mr. Davis	X	.....	.....
Ms. Black		X	.....	Ms. Sanchez	X	.....	.....
Mr. Reed		X	.....	Mr. Higgins	X	.....	.....
Mr. Kelly		X	.....	Ms. Sewell	X	.....	.....
Mr. Renacci		X	.....	Ms. DelBene	X	.....	.....
Mr. Meehan		X	.....	Ms. Chu	X	.....	.....
Ms. Noem		X	.....			
Mr. Holding		X	.....			
Mr. Smith (MO)		X	.....			
Mr. Rice		X	.....			
Mr. Schweikert		X	.....			
Ms. Walorski		X	.....			
Mr. Curbelo		X	.....			
Mr. Bishop		X	.....			

The legislation was ordered favorably transmitted to the House Committee on the Budget as amended by a roll call vote of 24 yeas and 15 yeas (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins	X	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sanchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	.....	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

IV. BUDGET EFFECTS OF THE PROVISIONS

A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the “Budget Reconciliation Legislative Recommendation Relating to Repeal of Tanning Tax.”

The budget reconciliation legislative recommendation, as transmitted, is estimated to have the following effects on budget receipts for fiscal years 2017–2026:

Fiscal years in billions of dollars											
2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–21	2017–26
--	--	[1]	–0.1	–0.1	–0.1	–0.1	–0.1	–0.1	–0.1	–0.2	–0.6

Note: Details do not add to totals due to rounding.

¹ Loss of less than \$50 million.

Pursuant to clause 8 of rule XIII of the Rules of the House of Representatives, the following statement is made by the Joint Committee on Taxation with respect to the provisions of the budget reconciliation legislative recommendation amending the Internal Revenue Code of 1986: the gross budgetary effect (before incorporating macroeconomic effects) in any fiscal year is less than 0.25 percent of the current projected gross domestic product of the United States for that fiscal year; therefore, the bill is not “major legislation” for purposes of requiring that the estimate include the budgetary effects of changes in economic output, employment, capital stock and other macroeconomic variables.

B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES BUDGET AUTHORITY

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the budget reconciliation legislative recommendation involves no new or increased budget authority. The Committee states further that the budget reconciliation legislative recommendation involves no new or increased tax expenditures.

C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, refer to Subtitle E.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee advises that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated into the description portions of this report.

B. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the budget reconciliation legislative recommendation contains no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizing funding is required.

C. INFORMATION RELATING TO UNFUNDED MANDATES

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104-4).

The Committee has determined that the budget reconciliation legislative recommendation does not contain any private sector mandates. The Committee has determined that the budget reconciliation legislative recommendation does not impose any Federal intergovernmental mandates on State, local, or tribal governments.

D. APPLICABILITY OF HOUSE RULE XXI 5(b)

Rule XXI 5(b) of the Rules of the House of Representatives provides, in part, that “A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting, a quorum being present.” The Committee has carefully reviewed the provisions of the budget reconciliation legislative recommendation and states that the provisions of the legislative recommendation does not involve any Federal income tax rate increases within the meaning of the rule.

E. TAX COMPLEXITY ANALYSIS

Section 4022(b) of the Internal Revenue Service Restructuring and Reform Act of 1998 (“IRS Reform Act”) requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses.

Pursuant to clause 3(h)(1) of rule XIII of the Rules of the House of Representatives, the staff of the Joint Committee on Taxation has determined that a complexity analysis is not required under section 4022(b) of the IRS Reform Act because the budget reconciliation legislative recommendation contains no provisions that amend the Code and that have “widespread applicability” to individuals or small businesses, within the meaning of the rule.

F. CONGRESSIONAL EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the budget reconciliation legislative recommendation and states that the provisions of the legislative recommendation do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

G. DUPLICATION OF FEDERAL PROGRAMS

In compliance with clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee states that the budget reconciliation legislative recommendation does not establish or reauthorize: (1) a program of the Federal Government known to be duplicative of another Federal program, (2) a program included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to section 6104 of title 31, United States Code.

H. DISCLOSURE OF DIRECTED RULE MAKINGS

In compliance with Sec. 3(i) of H. Res. 5 (115th Congress), the following statement is made concerning directed rule makings: The Committee advises that the budget reconciliation legislative recommendation requires no directed rule makings within the meaning of such section.

VI. CHANGES IN EXISTING LAW MADE BY THE BUDGET RECONCILIATION LEGISLATIVE RECOMMENDATIONS, AS TRANSMITTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes to existing law made by the recommendations, as reported, are shown in Subtitle E of title II.

VII. DISSENTING VIEWS

DISSENTING VIEWS ON RECOMMENDATION TO REPEAL THE TANNING TAX, COMMITTEE PRINT 2

1. Donald Trump promised that “we’re going to have insurance for everybody . . . [but it will be] much less expensive and much better.” This bill reveals those promises for what they always were: empty campaign rhetoric.”—Families USA¹

2. “We cannot support the AHCA as drafted because of the expected decline in health insurance coverage and the potential harm it would cause to vulnerable patient populations.”—American Medical Association²

3. “Repeal-and-replace is a gigantic transfer of wealth from the lowest-income Americans to the highest-income Americans.”—Edward D. Kleinbard, former chief of staff for the Joint Committee on Taxation and professor, University of Southern California School of Law.³

The five reconciliation legislative recommendations considered by the Committee on the Ways and Means (the “Committee”) and referred to the Committee on Budget (collectively, the Ways and Means reconciliation package or the “reconciliation package”) was a far-reaching attempt to undermine our health systems from Medicare to employer sponsored health insurance in order to give tax cuts to the wealthiest and corporations. After almost 18 hours of debate, the Committee mark-up ended with a party-line vote on the reconciliation package, which is likely to take health insurance away from millions of Americans. This reconciliation package, coupled with what was passed out of the Energy and Commerce Committee, would harm access to health care for middle-class Americans and undermine Medicare’s long-term viability while cutting taxes for corporations and the wealthiest Americans.

The Committee moved forward irresponsibly, without any official accounting about the estimated effect of the reconciliation package on health insurance coverage, out-of-pocket costs, or premium increases. While the Joint Committee on Taxation (JCT) estimated that the reconciliation package includes nearly \$600 billion worth of tax breaks, as of the mark-up, the Congressional Budget Office (CBO) was unable to provide estimates about the package’s effect on American families. Additionally the JCT score was incomplete as of the mark-up and did not provide an official accounting of all of the provisions considered by the Committee. Both the Ways and Means and Energy and Commerce Committees moved forward to pass recommendations out of each Committee without any sense

¹ <http://familiesusa.org/blog/2017/03/healthy-and-wealthy-benefit-under-house-republican-affordable-care-act-repeal-plan>

² <https://www.ama-assn.org/sites/default/files/media-browser/public/washington/ama-letter-on-ahca.pdf>.

³ <https://www.nytimes.com/2017/03/10/business/tax-cuts-affordable-care-act-repeal.html?r=I>.

from CBO of coverage losses due to the severe cuts to Medicaid, the repeal of the individual and employer-shared responsibility provisions of current law, or the changes in the tax credits available to help purchase health insurance on the individual market.

CBO provided the Committee an estimate of the effects *after* the reconciliation package was reported to the Committee on Budget from the Ways and Means and Energy and Commerce Committees. This estimate showed that 24 million Americans would lose coverage, with 14 million Americans losing coverage in the first year alone.

The Committee's reconciliation package provided generous tax cuts to the wealthiest, while reducing health insurance assistance for middle-class Americans. The tax breaks considered by the Committee are focused on wealthy individuals and corporations, instead of on middle-class Americans. About \$275 billion in tax breaks would benefit high-income earners; about 62% of the tax breaks would go to millionaires in 2020. Businesses and corporations receive nearly \$192 billion in tax cuts. These and other tax breaks add up to nearly \$600 billion in lost revenue.

Democrats objected strenuously to the Republican approach and instead believe the Committee should focus on policies that matter to middle-class Americans under the jurisdiction of this Committee, including financing long-term infrastructure, reforming the tax system to address income inequality, and further building on President Obama's record of job creation. Democrats believe that the reconciliation package will destabilize the health insurance market, which represents 18 percent of our gross domestic product.

The reconciliation package continues Republican efforts to undermine and destabilize the health insurance market. It undermines current law and the stability of both the individual and group health insurance markets by gutting individual and employer-shared responsibility provisions. The reconciliation package would reduce the uptake of the premium tax credits and the Medicaid expansion established in the Affordable Care Act (ACA), which have made health care affordable for millions of individuals. Reduced uptake of the Medicaid expansion and the tax credits disproportionately impacts low- and middle-income Americans and places them at risk for health insecurity and unexpected medical expenses. Based on independent estimates, roughly 24 million Americans would lose their insurance coverage because of this reconciliation package when taken together with the reconciliation recommendations passed by the Energy and Commerce Committee.⁴ Further, this reconciliation package reduces the life of the Medicare Trust Fund by three years by reducing \$170 billion from the Medicare Trust Fund, which puts Medicare at risk for 57 million seniors and individuals with disabilities.

Individual and employer-shared responsibility provisions are key to maintaining the robust and healthy risk pools that allow the ACA health insurance reforms to improve consumer protections while controlling health care costs. This is because well-functioning insurance markets rely on participation of both healthy and sick in-

⁴ <https://www.brookings.edu/blog/up-front/2017/03/09/expect-the-cbo-to-estimate-large-coverage-losses-from-the-gop-health-care-plan/>.

dividuals to spread risk across the pool. The reconciliation package effectively would repeal the individual and employer-shared responsibility penalty, leading to premium increases of an estimated 20 percent in the individual market alone. In spite of President Trump's and Congressional Republicans' efforts to sabotage the ACA, millions of Americans have enrolled in the health insurance Marketplaces, many using the available financial assistance, and millions more have enrolled in expanded Medicaid programs.

Despite promises made by President Trump, the reconciliation package would not cover more people or offer more affordable coverage with comparable benefits. Instead, this package leads to an estimated coverage loss of 24 million people while gutting benefits and consumer protections as a mechanism for affordability. When coupled with the legislation passed out of the Energy and Commerce Committee, the reconciliation package would return to a time when the market once again discriminates against those with pre-existing conditions and leaves those that might need medical care in the future without meaningful coverage. The reconciliation package provides for tax credits less generous than current law with no assistance with out-of-pocket expenses. Instead, the reconciliation package enshrines high deductible health plans that would increase out-of-pocket expenses. However, these plans do not address the underlying issues of access to quality services and the cost of care.

Since January of 2009, the Republicans voted to repeal or undermine the ACA more than 65 times. Democrats offered a number of amendments in Committee to point out serious flaws with the reconciliation package. For example, at the beginning of the markup, Democrats asked Republicans to postpone markup until CBO could provide a comprehensive report on costs, coverage losses, and premium effects of the reconciliation package.

In that regard, Congressman Lloyd Doggett (D-TX) offered a motion to postpone the markup for one week to allow time for review of the bill and the CBO estimate that was not available prior to or during the markup. For over four decades, CBO has been recognized as the official referee of costs and effects of legislation passed in the House and Senate. Congress relies on CBO's non-partisan estimates to evaluate legislative proposals. Democrats were concerned that Republicans deliberately moved forward with the reconciliation package without a CBO score in an effort to conceal the harmful effects of the reconciliation package on nearly all Americans.

The contrast of this rushed process versus the lengthy and transparent process of enacting the ACA is striking. In 2009, House Committees posted a draft of the ACA legislation for review and comment a month before the mark-up process began, holding multiple hearings and providing the public with two preliminary CBO estimates on July 8th and July 14th. Democrats maintain that there is no reason to rush to mark-up this reconciliation package without a CBO score, or without a hearing to consider the implications of the package. Congressman Doggett's amendment was tabled on a party line vote.

The Republican legislation would repeal a 10 percent tax on tanning beds. Tanning salons have been the subject of much con-

troversy for dishonest and misleading marketing, not to mention that improper use can be a health hazard. The World Health Organization and the National Toxicology Program classify indoor tanning beds as a “known” human carcinogen.⁵ The Melanoma Research Foundation found that as many as 90 percent of all melanoma cases are estimated to be caused by ultraviolet (UV) exposure. This includes UV exposure from the sun and from artificial sources, such as tanning beds.⁶ The Centers for Disease Control and Prevention warns that people who begin tanning during adolescence or early adulthood have a higher risk of melanoma, the deadliest type of skin cancer.

According to the 2015 Youth Risk Behavior Surveillance System, indoor tanning is used by 7 percent of all high school students, 11 percent of high school girls, 16 percent of girls in the 12th grade and 15 percent of all white high school girls.⁷ Using tanning beds before age 30 has been found to increase one’s risk of developing melanoma by 75 percent.⁸ The American Academy of Dermatology said in a letter to the Committee, “The tanning tax appropriately reflects the carcinogenic effects of indoor tanning, and it is the desire of the Academy that the current federal tax on this activity remains in place as a deterrent to harmful behavior.” Citing these and other public health concerns, Congresswoman Sanchez (D–CA) offered an amendment to strike the repeal of the tanning tax, which was defeated on party lines.

RICHARD E. NEAL,
Ranking Member.

⁵ False and Misleading Health Information Provided to Teens by the Indoor Tanning Industry: Investigative Report, U.S. House of Representatives Committee on Energy and Commerce Minority Staff, February 1, 2012.

⁶ <https://www.melanoma.org/understand-melanoma/preventing-melanoma/why-is-tanning-dangerous>

⁷ https://www.cdc.gov/cancer/skin_basic_info/indoor_tanning.htm

⁸ <https://www.melanoma.org/understand-melanoma/preventing-melanoma/why-is-tanning-dangerous>

COMMITTEE PRINT

Budget Reconciliation Legislative Recommendations Relating to Repeal of Tanning Tax

Subtitle ____—Repeal of Tanning Tax

SEC. __ 1. 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, 2017.

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SUBTITLE [D]—REMUNERATION FROM CERTAIN INSURERS

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

In fulfillment of the reconciliation instructions included in section 2002 of the Concurrent Resolution on the Budget for Fiscal Year 2017 (S. Con. Res. 3), the Committee on Ways and Means ordered favorably transmitted (with a quorum being present) the Budget Reconciliation Legislative Recommendations Relating to Remuneration from Certain Insurers. The Committee recommends repeal of section 162(m)(6) of the Internal Revenue Code of 1986 (“Code”),¹ which precludes a health insurer from deducting compensation provided to a service provider for a year to the extent the compensation exceeds \$500,000.

B. BACKGROUND AND NEED FOR LEGISLATION

As the Committee continues to actively pursue comprehensive health care reform to relieve unnecessary burdens on the broader economy and on taxpayers in need of access to quality health care, the Committee believes that providing immediate relief from taxes imposing excessive constraints on choices and innovation serves as an important first step toward its broader goals. The Committee believes that repealing the deduction limit on compensation provided by certain health insurers to service providers will better enable such insurers to obtain the services needed to operate efficiently without reducing after-tax profits for investors or limiting additional benefits from being passed onto consumers. The Committee believes that health insurance providers should not be treated differently than other types of businesses for the purposes of deducting compensation.

C. LEGISLATIVE HISTORY

Budget resolution

On January 13, 2017, the House of Representatives approved S. Con. Res. 3, the budget resolution for fiscal year 2017. Pursuant to section 2002(a)(3) of S. Con. Res. 3, the Committee on Ways and Means was directed to submit to the Committee on the Budget recommendations for changes in law within the jurisdiction of the Committee on Ways and Means sufficient to reduce the deficit by \$1,000,000,000 for the period of fiscal years 2017 through 2026.

Committee action

Beginning March 8, 2017, in response to its instructions under the budget resolution, the Committee on Ways and Means marked up the budget reconciliation legislative recommendations relating to remuneration from certain insurers and ordered the legislative recommendations, as amended, favorably transmitted (with a quorum being present) on March 9, 2017.

¹ All section references herein are to the Code unless otherwise stated.

Committee hearings

The Committee on Ways and Means held hearings regarding the President's Fiscal Year 2017 budget submission on February 11, 2016, and February 10, 2016 with Secretary of the Treasury Jacob J. Lew and Secretary of Health and Human Services Sylvia Burwell, respectively, in which the harmful effects of ACA taxes were discussed. Moreover, the Oversight Subcommittee held a hearing on March 5, 2013, discussing the tax-related provisions of the ACA.

II. EXPLANATION OF PROVISION**A. REPEAL OF DEDUCTION LIMIT ON REMUNERATION FROM HEALTH INSURANCE PROVIDERS****PRESENT LAW**

An employer generally may deduct reasonable compensation for personal services as an ordinary and necessary business expense.² However, in the case of a covered health insurance provider, the deduction allowable for compensation attributable to services performed by an applicable individual during a taxable year ("applicable individual remuneration") is limited to \$500,000.³ In general, an insurance provider is a covered health insurance provider if at least 25 percent of the insurance provider's gross premium income from health business is derived from health insurance plans that provide minimum essential coverage.⁴ Applicable individuals include all officers, employees, directors, and other workers or service providers (such as consultants) performing services for or on behalf of a covered health insurance provider.

Applicable individual remuneration includes all otherwise deductible compensation for a year except for payments to a qualified retirement plan (including salary reduction contributions) and benefits that are excludable from the applicable individual's gross income.⁵ The deduction limit applies without regard to whether compensation is otherwise deductible for the taxable year during which services are performed or a subsequent taxable year. In the case of compensation that relates to services that an applicable individual performs during a taxable year, but that is not deductible until a later year, such as nonqualified deferred compensation, the unused portion (if any) of the \$500,000 limit for the year is carried forward until the year in which the compensation is otherwise de-

²Sec. 162. However, under section 162(m)(1), in the case of a publicly held corporation, a deduction limit of \$1 million generally applies to compensation of the principal executive officer or the three most highly compensated officers for the taxable year other than the principal executive officer. Certain types of compensation are excepted from the limit, including remuneration payable on a commission basis ("commission compensation") and, if certain outside director and shareholder approval requirements are met, remuneration payable solely on account of the attainment of one or more performance goals ("performance-based compensation").

³Sec. 162(m)(6). All members of any controlled group of corporations (within the meaning of section 414(b)), other businesses under common control (within the meaning of section 414(c)), or affiliated service group (within the meaning of section 414(m) and (o)) are generally treated as a single employer for purposes of the deduction limit.

⁴Minimum essential coverage is defined in section 5000A(f).

⁵Exceptions for commission compensation and performance-based compensation do not apply for purposes of this limit.

ductible, and the remaining unused limit is then applied to the compensation.

REASONS FOR CHANGE

The Committee believes that the limit on the amount of compensation that a covered health insurer may deduct with respect to a service provider interferes with the insurer's ability to retain the services needed to operate most efficiently. In some cases, an insurer must either provide lower compensation, which limits its choice of service providers, or forego a compensation deduction, which reduces after-tax profits for investors or limits additional benefits from being passed onto consumers. The Committee believes that health insurance providers should not be treated differently than other types of businesses for the purposes of deducting compensation.

EXPLANATION OF PROVISION

Under the provision, the limit on the deduction of a covered health insurance provider for compensation attributable to services performed by an applicable individual no longer applies.

EFFECTIVE DATE

The provision is effective for taxable years beginning after December 31, 2017.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of the Reconciliation Legislative Recommendations Relating to Remuneration from Certain Insurers on March 8, 2017.

Mr. Tiberi's motion to table Mr. Doggett's motion to postpone was agreed to by a roll call vote of 22 yeas to 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE) .....	.....	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins .....	.....	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

Mr. Tiberi's motion to table Mr. Blumenauer's appeal of the ruling of the Chair was agreed to by a roll call vote of 23 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins .....	.....	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

Mr. Tiberi's motion to table Mr. Doggett's appeal of the ruling of the Chair was agreed to by a roll call vote of 23 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins .....	.....	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

Mr. Tiberi's motion to table Mr. Levin's appeal of the ruling of the Chair was agreed to by a roll call vote of 23 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins .....	.....	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

Mr. Tiberi's motion to table Mr. Crowley's appeal of the ruling of the Chair was agreed to by a roll call vote of 23 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins .....	.....	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

Mr. Tiberi's motion to table Mr. Kind's appeal of the ruling of the Chair was agreed to by a roll call vote of 23 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins .....	.....	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

Mr. Tiberi's motion to table Mr. Neal's appeal of the ruling of the Chair was agreed to by a roll call vote of 23 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins .....	.....	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

Mr. Tiberi's motion to table Mr. Higgins's appeal of the ruling of the Chair was agreed to by a roll call vote of 23 yeas and 15 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins .....	.....	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	.....	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

Mr. Tiberi's motion to table Mr. Thompson's appeal of the ruling of the Chair was agreed to by a roll call vote of 23 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins .....	.....	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

Mr. Tiberi's motion to table Mr. Lewis's appeal of the ruling of the Chair was agreed to by a roll call vote of 23 yeas and 15 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins .....	.....	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	.....	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

Mr. Tiberi's motion to table Mr. Pascrell's appeal of the ruling of the Chair was agreed to by a roll call vote of 22 yeas and 15 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam .....	.....	.....	.....	Mr. Larson .....	.....	X	.....

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins .....	.....	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	.....	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

Mr. Tiberi's motion to table Mr. Davis's appeal of the ruling of the Chair was agreed to by a roll call vote of 20 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins .....	.....	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly .....	.....	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO) .....	.....	.....	.....	
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo .....	.....	.....	.....	
Mr. Bishop	X	.....	.....		

Mr. Tiberi's motion to table Ms. Sewell's appeal of the ruling of the Chair was agreed to by a roll call vote of 23 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins .....	.....	.....	.....	Mr. Pascrell .....	.....	X	.....

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

Mr. Tiberi's motion to table Ms. Sánchez's appeal of the ruling of the Chair was agreed to by a roll call vote of 23 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins .....	.....	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

The legislation was ordered favorably transmitted to the House Committee on the Budget as amended by a roll call vote of 23 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins .....	.....	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

IV. BUDGET EFFECTS OF THE PROVISION

A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the “Budget Reconciliation Legislative Recommendations Relating to Remuneration from Certain Insurers.”

The budget reconciliation legislative recommendations, as transmitted, are estimated to have the following effects on budget receipts for fiscal years 2017–2026:

By fiscal years, in billions of dollars—											
2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017– 21	2017– 26
— — —	[1]	[1]	[1]	– 0.1	– 0.1	– 0.1	– 0.1	– 0.1	– 0.1	– 0.1	– 0.4

NOTE: Details do not add to totals due to rounding.

Pursuant to clause 8 of rule XIII of the Rules of the House of Representatives, the following statement is made by the Joint Committee on Taxation with respect to the provisions of the bill amending the Internal Revenue Code of 1986: the gross budgetary effect (before incorporating macroeconomic effects) in any fiscal year is less than 0.25 percent of the current projected gross domestic product of the United States for that fiscal year; therefore, the bill is not “major legislation” for purposes of requiring that the estimate include the budgetary effects of changes in economic output, employment, capital stock and other macroeconomic variables.

B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES BUDGET AUTHORITY

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the budget reconciliation legislative recommendation involves no new or increased budget authority. The Committee states further that the budget reconciliation legislative recommendation involves no new or increased tax expenditures.

C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET
OFFICE

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, refer to Subtitle E.

**V. OTHER MATTERS TO BE DISCUSSED UNDER THE
RULES OF THE HOUSE**

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee advises that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated into the description portions of this report.

B. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the budget reconciliation legislative recommendations contain no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizing funding is required.

C. INFORMATION RELATING TO UNFUNDED MANDATES

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104-4).

The Committee has determined that the budget reconciliation legislative recommendations do not contain any private sector mandates. The Committee has determined that the budget reconciliation legislative recommendations do not impose any Federal intergovernmental mandates on State, local, or tribal governments.

D. APPLICABILITY OF HOUSE RULE XXI 5(b)

Rule XXI 5(b) of the Rules of the House of Representatives provides, in part, that “A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting, a quorum being present.” The Committee has carefully reviewed the provisions of the budget reconciliation legislative recommendations and states that the provisions of the legislative recommendations do not involve any Federal income tax rate increases within the meaning of the rule.

E. TAX COMPLEXITY ANALYSIS

Section 4022(b) of the Internal Revenue Service Restructuring and Reform Act of 1998 (“IRS Reform Act”) requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all leg-

islation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses.

Pursuant to clause 3(h)(1) of rule XIII of the Rules of the House of Representatives, the staff of the Joint Committee on Taxation has determined that a complexity analysis is not required under section 4022(b) of the IRS Reform Act because the budget reconciliation legislative recommendation contains no provisions that amend the Code and that have “widespread applicability” to individuals or small businesses, within the meaning of the rule.

F. CONGRESSIONAL EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the budget reconciliation legislative recommendations and states that the provisions of the legislative recommendations do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

G. DUPLICATION OF FEDERAL PROGRAMS

In compliance with clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee states that the budget reconciliation legislative recommendation does not establish or reauthorize: (1) a program of the Federal Government known to be duplicative of another Federal program, (2) a program included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to section 6104 of title 31, United States Code.

H. DISCLOSURE OF DIRECTED RULE MAKINGS

In compliance with Sec. 3(i) of H. Res. 5 (115th Congress), the following statement is made concerning directed rule makings: The Committee advises that the budget reconciliation legislative recommendations require no directed rule makings within the meaning of such section.

VI. CHANGES IN EXISTING LAW MADE BY THE BUDGET RECONCILIATION LEGISLATIVE RECOMMENDATION, AS TRANSMITTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes to existing law made by the recommendations, as reported, are shown in Subtitle E of title II.

VII. DISSENTING VIEWS

DISSENTING VIEWS ON RECOMMENDATION TO PROVIDE A TAX BREAK TO HEALTH INSURANCE COMPANIES THAT PAY EXCESSIVE EXECUTIVE COMPENSATION, COMMITTEE PRINT 1

1. Donald Trump promised that “we’re going to have insurance for everybody . . . [but it will be] much less expensive and much better.” This bill reveals those promises for what they always were: empty campaign rhetoric.”—Families USA¹

2. “We cannot support the AHCA as drafted because of the expected decline in health insurance coverage and the potential harm it would cause to vulnerable patient populations.”—American Medical Association²

3. “Repeal-and-replace is a gigantic transfer of wealth from the lowest-income Americans to the highest-income Americans.”—Edward D. Kleinbard, former chief of staff for the Joint Committee on Taxation and professor, University of Southern California School of Law.³

The five reconciliation legislative recommendations considered by the Committee on Ways and Means (the “Committee”) and referred to the Committee on Budget (collectively, the Ways and Means reconciliation package or the “reconciliation package”) was a far-reaching attempt to undermine our health systems from Medicare to employer sponsored health insurance in order to give tax cuts to the wealthiest and corporations. After almost 18 hours of debate, the Committee mark-up ended with a party-line vote on the reconciliation package, which is likely to take health insurance away from millions of Americans. This reconciliation package, coupled with what was passed out of the Energy and Commerce Committee, would harm access to health care for middle-class Americans and undermine Medicare’s long-term viability while cutting taxes for corporations and the wealthiest Americans.

The Committee moved forward irresponsibly, without any official accounting about the estimated effect of the reconciliation package on health insurance coverage, out-of-pocket costs, or premium increases. While the Joint Committee on Taxation (JCT) estimated that the reconciliation package includes nearly \$600 billion worth of tax breaks, as of the mark-up, the Congressional Budget Office (CBO) was unable to provide estimates about the package’s effect on American families. Additionally the JCT score was incomplete as of the mark-up and did not provide an official accounting of all of the provisions considered by the Committee. Both the Ways and

¹ <http://familiesusa.org/blog/2017/03/healthy-and-wealthy-benefit-under-house-republican-affordable-care-act-repeal-plan>

² <https://www.ama-assn.org/sites/default/files/media-browser/public/washington/ama-letter-on-ahca.pdf>

³ https://www.nytimes.com/2017/03/10/business/tax-cuts-affordable-care-act-repeal.html?_r=1

Means and Energy and Commerce Committees moved forward to pass recommendations out of each Committee without any sense from CBO of coverage losses due to the severe cuts to Medicaid, the repeal of the individual and employer-shared responsibility provisions of current law, or the changes in the tax credits available to help purchase health insurance on the individual market.

CBO provided the Committee an estimate of the effects *after* the reconciliation package was reported to the Committee on Budget from the Ways and Means and Energy and Commerce Committees. This estimate showed that 24 million Americans would lose coverage, with 14 million Americans losing coverage in the first year alone.

The Committee's reconciliation package provided generous tax cuts to the wealthiest, while reducing health insurance assistance for middle-class Americans. The tax breaks considered by the Committee are focused on the wealthy individuals and corporations, instead on middle-class Americans. About \$275 billion in tax breaks would benefit high-income earners; about 62% of the tax breaks would go to millionaires in 2020. Businesses and corporations would receive nearly \$192 billion in tax cuts. These and other tax breaks add up to nearly \$600 billion in lost revenue.

Democrats objected strenuously to the Republican approach and instead believe the Committee should focus on policies that matter to middle-class Americans under the jurisdiction of this Committee, including financing long-term infrastructure, reforming the tax system to address income inequality, and further building on President Obama's record of job creation. Democrats believe that the reconciliation package will destabilize the health insurance market, which represents 18 percent of our gross domestic product.

The reconciliation package continues Republican efforts to undermine and destabilize the health insurance market. It undermines current law and the stability of both the individual and group health insurance markets by gutting individual and employer-shared responsibility provisions. The reconciliation package would reduce the uptake of the premium tax credits and the Medicaid expansion established in the Affordable Care Act (ACA), which have made health care affordable for millions of individuals. Reduced uptake of the Medicaid expansion and the tax credits disproportionately impacts low- and middle-income Americans and places them at risk for health insecurity and unexpected medical expenses. Based on independent estimates, roughly 24 million Americans would lose their insurance coverage because of this reconciliation package when taken together with the reconciliation recommendations passed by the Energy and Commerce Committee.⁴ Further, this reconciliation package reduces the life of the Medicare Trust Fund by three years by reducing \$170 billion from the Medicare Trust Fund, which puts Medicare at risk for 57 million seniors and individuals with disabilities.

Individual and employer-shared responsibility provisions are key to maintaining the robust and healthy risk pools that allow the ACA health insurance reforms to improve consumer protections

⁴ <https://www.brookings.edu/blog/up-front/2017/03/09/expect-the-cbo-to-estimate-large-coverage-losses-from-the-gop-health-care-plan/>

while controlling health care costs. This is because well-functioning insurance markets rely on participation of both healthy and sick individuals to spread risk across the pool. The reconciliation package effectively would repeal the individual and employer-shared responsibility penalty, leading to premium increases of an estimated 20 percent in the individual market alone. In spite of President Trump and Congressional Republicans' efforts to sabotage the ACA, millions of Americans have enrolled in the health insurance Marketplaces, many using the available financial assistance, and millions more have enrolled in expanded Medicaid programs.

Despite promises made by President Trump, the reconciliation package would not cover more people or offer more affordable coverage with comparable benefits. Instead, this package leads to an estimated coverage loss of 24 million people while gutting benefits and consumer protections as a mechanism for affordability. When coupled with the legislation passed out of the Energy and Commerce Committee, the reconciliation package would return to a time when the market once again discriminates against those with pre-existing conditions and leaves those that might need medical care in the future without meaningful coverage. The reconciliation package provides for tax credits less generous than current law with no assistance with out-of-pocket expenses. Instead, the reconciliation package enshrines high deductible health plans that would increase out-of-pocket expenses. However, these plans do not address the underlying issues of access to quality services and the cost of care.

Since January of 2009, the Republicans voted to repeal or undermine the ACA more than 65 times. Democrats offered a number of amendments in Committee to point out serious flaws with the reconciliation package. For example, at the beginning of the mark up, Democrats asked Republicans to postpone mark up until CBO could provide a comprehensive report on costs, coverage losses, and premium effects of the reconciliation package.

In that regard, Congressman Lloyd Doggett (D-TX) offered a motion to postpone the markup for one week to allow time for review of the bill and the CBO estimate that was not available prior to or during the mark up. For over four decades, CBO has been recognized as the official referee of costs and effects of legislation passed in the House and Senate. Congress relies on CBO's non-partisan estimates to evaluate legislative proposals. Democrats were concerned that Republicans deliberately moved forward with the reconciliation package without a CBO score in an effort to conceal the harmful effects of the reconciliation package on nearly all Americans.

The contrast of this rushed process versus the lengthy and transparent process of enacting the ACA is striking. In 2009, House Committees posted a draft of the ACA legislation for review and comment a month before the mark-up process began, holding multiple hearings and providing the public with two preliminary CBO estimates on July 8th and July 14th. Democrats maintain that there is no reason to rush to mark-up this reconciliation package without a CBO score, or without a hearing to consider the implications of the package. Congressman Doggett's amendment was tabled on a party line vote.

The reconciliation recommendation contained in this Committee Print gives a \$400 million tax break to corporations by providing a deduction for health insurance company executive salaries in excess of \$500,000. In 2013, the 10 biggest health insurance companies paid their top 57 executives a total of \$300 million. Democrats expressed significant concerns that this reconciliation recommendation was a boondoggle for health insurance company executives. Because the ACA capped the amount insurance companies could deduct for executive salaries at a lower amount, these companies were able to deduct only 27% of this total. If the Republicans reopen this loophole, these insurance companies would be able to deduct 96%.⁵ Opening a tax loophole for executive compensation would do nothing to make insurance more affordable for middle-class Americans.

The reconciliation recommendations before the Committee were structured in such a way to significantly curtail the germaneness of amendments that Democrats might wish to offer. Nevertheless, Democrats offered a series of amendments to highlight the reconciliation package's serious shortcomings, virtually all of which were ruled non-germane by Chairman Kevin Brady (R-TX) and appealed by Democrat Members. The appeals were then defeated by party-line votes.

Congressman Earl Blumenauer (D-OR) offered an amendment to ensure the reconciliation package met the test that President Trump laid out for his health care plan. The amendment stated that the reconciliation package does not take effect unless the CBO certifies that everybody gets health insurance as a result of the package. President Trump noted, "Everybody's got to be covered. This is an un-Republican thing for me to say because a lot of times they say, 'No, no, the lower 25 percent that can't afford private.' But—I am going to take care of everybody. I don't care if it costs me votes or not. Everybody's going to be taken care of much better than they're taken care of now . . . They're going to be taken care of."⁶ Chairman Brady ruled the amendment not in order.

Tax Policy Subcommittee Ranking Member Congressman Doggett (D-TX) offered an amendment to request that the Ways and Means Committee use its oversight authority to obtain and review President Trump's tax returns from the Treasury Department in accordance with 6103(f)(1). Chairman Brady ruled the amendment not in order.

Health Subcommittee Ranking Member Levin (D-MI) offered an amendment to require that a CBO score of the GOP health care bill be made public for at least 7 days before a vote on the bill in the House, to allow for transparency and time for Members and the public to understand the effects of the legislation. Despite Chairman Brady's call for transparency, Chairman Brady ruled the amendment not in order.

Congressman Joe Crowley (D-NY) offered an amendment identical to one that Chairman Brady offered in the 2009 mark up of the health care bill relating to transparency. The amendment would have expressed the Sense of the Congress that prior to vot-

⁵ http://www.ips-dc.org/wp-content/uploads/2014/08/EE14_Final1.pdf

⁶ <http://www.cbsnews.com/news/donald-trump-60-minutes-scott-pelley/>

ing on this bill, each Member certifies in the Congressional Record that he or she has read the entire bill. The amendment would further express the sense that the bill should be available to the public for 72 hours prior to the vote. Although this exact amendment was ruled germane in 2009 by then Chairman Charles Rangel (D-NY), Chairman Brady ruled the amendment not in order.

Given the reconciliation package proposes enormous tax cuts of nearly \$600 billion and likely dramatic declines in the number of Americans with health insurance, Congressman Ron Kind (D-WI) offered an amendment to promote fiscal and moral responsibility. His amendment would have required the Republican health care bill to be fully paid for and not increase the number of uninsured Americans. This amendment was again ruled not in order by Chairman Brady.

I offered an amendment to protect against job loss at local hospitals. Hospital associations have noted that repealing the ACA combined with the loss of health insurance for millions of Americans would lead to a large increase in uncompensated care that could threaten hospital viability. Uninsured people often must pay “up front” before services will be rendered. Between 2013 and 2014, total uncompensated care costs for hospitals (including charity care costs and bad debt) dropped from \$34.9 billion to \$28.9 billion, a \$6 billion or 17% drop, with nearly all of the decrease occurring in expansion states. One hospital association stated in response to this bill that, “Our hospitals could not sustain such reductions without scaling back services or eliminating jobs.”⁷ Repealing all or part of the ACA would increase the number of uninsured, increasing hospital uncompensated care costs and bad debt from unpaid medical bills. Chairman Brady ruled the amendment non-germane.

Congressman Brian Higgins (D-NY) offered an amendment to protect older Americans from increased costs or reduced benefits. Independent analysis indicated that under the GOP bill, in 2020 the average enrollee who purchases their own insurance would see costs increase by \$2,409. For those age 55–64, they would see costs increase \$6,971. Independent analyses found that this price increase for older Americans will cause nearly half-a-million older Americans to become uninsured.

Organizations representing older Americans have expressed serious concerns with the Republican proposal. AARP noted, “We write today to express our opposition to the *American Health Care Act*. This bill would weaken Medicare’s fiscal sustainability, dramatically increase health care costs for Americans aged 50–64, and put at risk the health care of millions of children and adults with disabilities, and poor seniors who depend on the Medicaid program for long-term services and supports and other benefits.” The organization continues to observe that, “Age rating plus premium increases equal an unaffordable age tax.” Chairman Brady ruled Congressman Higgins’ amendment out of order.

Congressman Mike Thompson (D-CA) offered an amendment that would enable states to opt out of the GOP health care bill and keep the health care options provided under the ACA. Millions of

⁷ <https://essentialhospitals.org/general/statement-on-house-reconciliation-legislation/>

Americans across the nation have benefitted from the past seven years of the Affordable Care Act. Others have comprehensive coverage today that they would like to keep. The Republican legislation replaces current flexible and consumer-friendly law with a one-size-fits-all Republican mandated plan that would impose significant hardship on states. Many Governors have expressed concern that repealing the ACA would harm their residents. Regarding the GOP plan, the Democratic Governors Association noted, “Yet the only flexibility being offered is deciding which of our vulnerable communities to deprive of health coverage—those battling opioid addiction, low-income families, senior citizens, or people with disabilities.”

Further building on the theme of ensuring Americans do not lose what they have today, Congressman John Lewis (D-GA) offered an amendment that would require that the Republican bill not result in loss of coverage or an increase in the number of uninsured individuals. The Brookings Institution estimates that coverage loss under the legislation could range from a low of 15 million to more than 20 million Americans.⁸ Adults who are uninsured are three times more likely than insured adults to say they have not seen or spoken with a medical provider about their health in the past year.⁹ Uninsured Americans are less likely to receive recommended screening tests such as blood pressure checks, cholesterol checks, blood sugar screening, pap smear or mammogram (among women), and colon cancer screening.¹⁰ Lacking insurance also is a major factor driving individuals into debt. Uninsured people are more likely than those with insurance (53% vs. 20%) to report having trouble paying or being unable to pay medical bills in the past year.¹¹ In 2015, 27% of uninsured adults reported that medical bills caused them to use up all or most of their savings, 21% said they led to difficulties paying for basic necessities, 22% said it led them to borrow money, and 27% said it led to being contacted by a collection agency.¹² Democrats believe it is important for health and financial security that Americans are able to retain insurance coverage. The coverage losses under the Republican bill are likely to worsen health outcomes and drive millions into debt. Chairman Brady ruled Congressman Thompson’s amendment out of order.

Congressman Bill Pascrell (D-NJ) offered an amendment to prevent middle-class tax increases and require the GOP health care bill to not increase taxes on families earning less than \$250,000 per year. This amendment was nearly identical to an amendment offered by Rep. Cathy McMorris Rodgers (R-WA) during the passage of the ACA in 2009. Democrats are concerned that while more than 60 percent of the tax giveaways in the Republican package go to millionaires, ordinary Americans will suffer tax increases as Republicans dramatically reduce the value of the tax subsidy for indi-

⁸ <https://www.brookings.edu/blog/up-front/2017/03/09/expect-the-cbo-to-estimate-large-coverage-losses-from-the-gop-health-care-plan/>

⁹ <http://files.kff.org/attachment/Report-The-Uninsured-A%20Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-in-America-in-the-Era-of-Health-Reform>

¹⁰ <http://files.kff.org/attachment/Report-The-Uninsured-A%20Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-in-America-in-the-Era-of-Health-Reform>

¹¹ <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>

¹² <http://kff.org/report-section/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-in-the-wake-of-national-health-reform-what-are-the-financial-implications-of-lacking-coverage/>

viduals purchasing their own health insurance. Chairman Brady again ruled this amendment out of order.

Congressman Danny Davis (D-IL) offered an amendment to prohibit provisions of the bill from taking effect if the Institute of Medicine certified that coverage for individuals with mental health and substance abuse issues would decrease, or out-of-pocket costs would increase. The United States is struggling to improve access to mental health treatment and also with an epidemic of opiate addiction. Numerous studies have documented that repealing current law, including provisions that extend coverage to working Americans, would set efforts to improve treatment for mental health and substance abuse back significantly.¹³ Chairman Brady ruled Congressman Davis' amendment out of order.

Recognizing that rural America has benefitted significantly from the current law, Congresswoman Terri Sewell (D-AL) offered an amendment to protect rural hospitals and jobs from the negative effects of the Republican bill. Rural individuals saw greater gains in insurance coverage under the Affordable Care Act compared with urban individuals (7.2 percentage point increase versus 6.3 percentage point increase for urban areas) and some rural communities experienced even larger decreases in the number of uninsured. Historically, rural residents are not only more likely to be uninsured but also suffer longer periods of uninsurance, leading rural residents to be denied coverage or charged more for pre-existing conditions. Further, rural communities tend to be high-cost areas for insurance coverage. As a result, the flat tax credits not pegged to local affordability would particularly harm rural communities. Decreased stability in insurance markets would make insurance companies less likely to offer comprehensive coverage in rural areas. The Republican bill undermines current law protections on access to affordable coverage and could disproportionately harm those in rural areas. Chairman Brady ruled Congressman Sewell's amendment out of order.

Congresswoman Linda Sánchez (D-CA) offered an amendment to repeal the high-cost plan excise tax (often called the Cadillac tax). The tax unfairly reduces health benefits for employees who have these plans, particularly those with expensive chronic illnesses. The AFL-CIO noted, "Far from providing an improvement on the coverage provided by the ACA, this Republican alternative will result in millions of Americans losing their coverage. . . . Estimates from the Mercer Firm find that by the time the AHCA imposes the tax in 2025, the coverage provided by more than 40% of employers with 50+ workers would be impacted by the tax. CBO predicts that the vast majority of employers confronted with this tax are expected to shift costs to their workers by increasing deductibles, copays, co-insurance, and maximum out of pocket limits to avoid paying the tax."¹⁴ One study notes, "The tax subsidy is a big help for people with (2009) family incomes of \$38,550 to \$100,000, but not for those with lower or higher incomes." The authors further comment that the new tax on benefits "will hit the middle class

¹³ <http://thehill.com/blogs/pundits-blog/healthcare/313672-keep-obamacare-to-keep-progress-on-treating-opioiddisorders>; https://www.acponline.org/system/files/documents/advocacy/where_we_stand/assets/fact_sheet_impact_a_ca_repeal_2016.pdf

¹⁴ AFL-CIO letter from William Samuels to Congresswoman Sánchez, March 8, 2017.

hardest and spare the wealthy.”¹⁵ The Republican bill repeals the revenue raisers in the Affordable Care Act that affect the wealthy and corporations, but would not repeal the tax that could affect middle-class workers. Chairman Brady ruled Congresswoman Sánchez’s amendment out of order.

Finally, once all amendments were voted down on partisan votes, Republicans defeated an amendment on party lines that would have struck the provision providing a tax break to health insurance companies.

RICHARD E. NEAL,
Ranking Member.

¹⁵ “The ‘Cadillac Tax’ on Health Benefits in the United States Will Hit the Middle Class Hardest: Refuting the Myth that Health Benefit Tax Subsidies Are Regressive,” by Steffie Woolhandler, M.D., M.P.H., and David U. Himmelstein, M.D., *International Journal of Health Services*, OnlineFirst ahead of print, first published on March 9, 2016, as doi:10.1177/0020731416637163

RANKING MEMBER RICHARD NEAL

OPENING STATEMENT

WAYS AND MEANS COMMITTEE ACA REPEAL MARKUP

WEDNESDAY, MARCH 8, 2017

Mr. Chairman, I am disappointed we are here today to consider legislation that reflects not only bad policy, but bad process. And a number of important groups agree: AARP, AMA and AHA all oppose this bill. This bill suffers from an identity crisis. Is this a health care bill or a tax cut bill?

Does it lower costs? No.

Does it bend the cost curve? No.

Does it cover more Americans? No.

Does it cut the deficit? No.

Even the President wants more information—earlier this year he called it an “unbelievably complex subject. Nobody knew healthcare could be so complicated.” This Republican bill—which they cleverly broke up into separate parts to try to distract the American public—fails to protect 152 million Americans with pre-existing conditions and would allow insurers to charge older people five times as much as younger people, essentially implementing an “age tax”. It forces millions to pay more for less care.

Transparency is clearly lacking in this process. As recently as last week, I called upon House Republicans to provide an open and transparent process when they consider any health care legislation aimed at repealing or replacing the Affordable Care Act. The goal: to ensure all Americans had the opportunity to fully understand and consider how any Republican health care plan could impact them. Instead, the Republicans hid a draft bill somewhere in the basement of the Capitol with armed police officers. That is as far as you can get from transparency. The American public deserve better from their representatives. Also to consider a bill of this magnitude without a CBO score is not only puzzling and concerning, but also irresponsible. When the Democrats created the Affordable Care Act, it was a thoroughly transparent and open process. Let’s look at the numbers:

In the House

- 79 bipartisan health insurance reform hearings and markups over 2 years
- 100 hours in hearings
- 181 witnesses from both sides of the aisle
- 239 Republican and Democrat amendments—121 were accepted
- 30 days of online review of the original House bill before the first markup
- 72 hours—number of hours the House bill was online for review before final vote
- 3,000 health care town halls and public events

In the Senate

- 53 health insurance reform hearings in the Senate Finance Committee
- 8 days of markups with 135 amendments considered in Senate Finance Committee
- 47 bipartisan hearings and other open dialogues with 300 amendments during a 13 day markup in the Senate HELP Committee
- 25 consecutive days in session to discuss health reform in the Senate
- 160 hours total in the Senate considering health reform legislation
- 147 Republican amendments in the final Senate bill

This bill sabotages the Marketplaces where close to 10 million Americans today get coverage and starts a death spiral from which we will never recover. Healthy people won't bother with coverage or only buy bare bones policies. Sick people who need coverage would buy policies—if they are even available—that will undoubtedly become more and more expensive and unaffordable, especially in light of the inadequate tax credits.

The most egregious part of the Republican plan slashes Medicaid funding to pay for tax cuts that benefit the rich. Medicaid helps pay the costs for more than 60% of all nursing home residents nationwide, and helps families afford quality nursing home care for their elderly parents and family members with disabilities. The Republican Medicaid proposal makes it harder and much costlier for families to find long-term care for elderly parents or children with severe disabilities.

In addition, it would end the Medicaid expansion—a move that would have devastating consequences in my state of Massachusetts where it has been a critical tool for thousands of individuals and families with loved ones in long-term care facilities or who have dementia. It also provides rehabilitation options for individuals and families in the grips of opioid addiction. The reality is that Medicaid is now a middle-class benefit.

The measure also would cut the span of Medicare by two years at a time when millions of baby boomers are joining and will rely heavily on this critical program. It's a \$170 billion tax giveaway to the wealthy, while starving the Medicare trust fund.

Hospitals would face crippling debt as they face increased uncompensated care and lower reimbursement rates. In turn, this would lead to job loss in many hospitals and have a negative ripple effect in communities where hospitals are the largest employer. For example, in Western Massachusetts, Baystate Healthy provides 12,000 jobs and has a \$4 billion statewide economic impact.

Let's call this bill what it is: a plan that creates chaos in the insurance market that directly impacts patients and providers, hurts hospitals, the communities they serve and their regional economies.

Before concluding, I would like to note that today's markup is really the Republicans' first step on tax reform. This legislation is a tax bill; almost every provision amends the Internal Revenue Code. So, we need to view this bill through the lens of tax reform as well. And through that lens, the bill fails the test set out by Secretary Mnuchin for tax reform that, "there will be no absolute tax

cut for the upper class.” The Republican bill absolutely provides a tax cut for the wealthy and health care industry of almost \$600 billion dollars. In fact, it has been estimated that 400 households with the highest-income would receive tax cuts averaging about \$7 million apiece each year. At the same time, the bill hurts the middle-class through less generous tax credits, cuts to Medicaid and higher premiums with less quality care.

Bottom line: this is ultimately about affordability. If Republicans take away critical coverage benefits in the ACA coupled with hurting the middle-class, it would drastically increase costs and lower coverage and quality care. As the Republicans have heard loud and clear during town halls, people are afraid of losing their health insurance. It would be irresponsible for Republicans to take away health care programs on which their constituents across a broad age and economic spectrum depend.

COMMITTEE PRINT

Budget Reconciliation Legislative Recommendations Relating to Remuneration from Certain Insurers

Subtitle ____—Remuneration From Certain Insurers

SEC. __1. REMUNERATION FROM CERTAIN INSURERS.

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

“(I) TERMINATION.—This paragraph shall not apply to taxable years beginning after December 31, 2017.”.

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SUBTITLE [E]—REPEAL OF NET INVESTMENT INCOME TAX

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

In fulfillment of the reconciliation instructions included in section 2002 of the Concurrent Resolution on the Budget for Fiscal Year 2017 (S. Con. Res. 3), the Committee on Ways and Means ordered favorably transmitted (with a quorum being present) the Budget Reconciliation Legislative Recommendations Relating to Repeal of the Net Investment Income Tax. The Committee recommends the repeal of the net investment income tax. The Patient Protection and Affordable Care Act of 2010 (“PPACA”), Pub. L. No. 111–148 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (“HCERA”), Pub. L. No. 111–152 (March 30, 2010),¹ imposes a tax of 3.8-percent on net investment income for taxpayers whose modified adjusted gross income exceeds \$250,000 (in the case of joint filers) and \$200,000 (in the case of other filers). The Committee’s recommendation strikes chapter 2A of subtitle A of the Internal Revenue Code of 1986, as added and amended by PPACA and HCERA.

B. BACKGROUND AND NEED FOR LEGISLATION

As the Committee continues to actively pursue comprehensive health care reform to relieve unnecessary burdens on the broader economy and on taxpayers in need of access to quality health care, the Committee believes that repealing the additional 3.8-percent tax on net investment income will improve the efficiency of capital markets and promote long-run economic growth.

C. LEGISLATIVE HISTORY

Budget resolution

On January 13, 2017, the House of Representatives approved S. Con. Res. 3, the budget resolution for fiscal year 2017. Pursuant to section 2002(a)(3) of S. Con. Res. 3, the Committee on Ways and Means was directed to submit to the Committee on the Budget recommendations for changes in law within the jurisdiction of the Committee on Ways and Means sufficient to reduce the deficit by \$1,000,000,000 for the period of fiscal years 2017 through 2026.

Committee action

Beginning March 8, 2017, in response to its instructions under the budget resolution, the Committee on Ways and Means marked up the budget reconciliation legislative recommendations relating to repeal of the tax on net investment income under PPACA and ordered the legislative recommendations, as amended, favorably transmitted (with a quorum being present) on March 9, 2017.

¹ PPACA and HCERA are collectively referred to as the Affordable Care Act (“ACA”).

Committee hearings

The Committee on Ways and Means held hearings regarding the President's Fiscal Year 2017 budget submission on February 11, 2016, and February 10, 2016, with Secretary of the Treasury Jacob J. Lew and Secretary of Health and Human Services Sylvia Burwell, respectively, in which the harmful effects of ACA taxes were discussed. Moreover, the Oversight Subcommittee held a hearing on March 5, 2013, discussing the tax-related provisions of the ACA.

II. EXPLANATION OF PROVISION**A. REPEAL OF NET INVESTMENT INCOME TAX****PRESENT LAW***In general*

A tax is imposed with respect to the net investment income of certain high-income individuals, estates and trusts.² In the case of an individual, the tax is 3.8 percent of the lesser of net investment income or the excess of modified adjusted gross income over the threshold amount.

The threshold amount is \$250,000 in the case of a joint return or surviving spouse, \$125,000 in the case of a married individual filing a separate return, and \$200,000 in any other case.

Modified adjusted gross income is adjusted gross income increased by the amount excluded from income as foreign earned income under section 911(a)(1) (net of the deductions and exclusions disallowed with respect to the foreign earned income).

In the case of an estate or trust, the tax is 3.8 percent of the lesser of undistributed net investment income or the excess of adjusted gross income (as defined in section 67(e)) over the dollar amount at which the highest income tax bracket applicable to an estate or trust begins.

The tax does not apply to a nonresident alien or to a trust, all the unexpired interests in which are devoted to charitable purposes. The tax also does not apply to a trust that is exempt from tax under section 501 or a charitable remainder trust exempt from tax under section 664.

The tax is subject to the individual estimated tax provisions. The tax is not deductible in computing any tax imposed by subtitle A of the Internal Revenue Code (relating to income taxes).

Net investment income

Net investment income is investment income reduced by the deductions properly allocable to such income.

Investment income is the sum of (i) gross income from interest, dividends, annuities, royalties, and rents (other than income derived from any trade or business to which the tax does not apply), (ii) other gross income derived from any business to which the tax applies, and (iii) net gain (to the extent taken into account in computing taxable income) attributable to the disposition of property

²Sec. 1411.

other than property held in a trade or business to which the tax does not apply.³

In the case of a trade or business, the tax applies if the trade or business is a passive activity with respect to the taxpayer or the trade or business consists of trading financial instruments or commodities (as defined in section 475(e)(2)). The tax does not apply to other trades or businesses conducted by a sole proprietor, partnership, or S corporation.

In the case of the disposition of a partnership interest or stock in an S corporation, gain or loss is taken into account only to the extent gain or loss would be taken into account by the partner or shareholder if the entity had sold all its properties for fair market value immediately before the disposition. Thus, only net gain or loss attributable to property held by the entity which is not property attributable to an active trade or business is taken into account.⁴

Income, gain, or loss on working capital is not treated as derived from a trade or business. Investment income does not include distributions from a qualified retirement plan or amounts subject to SECA tax.

REASONS FOR CHANGE

The Committee believes that the 3.8-percent tax on net investment income adversely affects the efficiency of capital markets, by discouraging taxpayers from disposing of their assets and reinvesting the proceeds in a more productive use, exacerbating the “lock-in” effect. Furthermore, the Committee believes that repealing the net investment income tax will promote savings and investment for households. Finally, the Committee believes that repealing the tax on net investment income will promote long-run economic growth.

DESCRIPTION OF PROVISION

The provision repeals the 3.8-percent tax on net investment income.

EFFECTIVE DATE

The provision is effective for taxable years beginning after December 31, 2017.

³Gross income does not include items, such as interest on tax-exempt bonds, veterans’ benefits, and excluded gain from the sale of a principal residence, which are excluded from gross income under the income tax.

⁴For this purpose, a business of trading financial instruments or commodities is not treated as an active trade or business.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of the Reconciliation Legislative Recommendations Relating to Repeal of the Net Investment Income Tax on March 8, 2017:

The vote on the amendment by Mr. Davis to the amendment in the nature of a substitute to Subtitle ____: Budget Reconciliation Legislative Recommendations Relating to Repeal of Net Investment Tax, which would require the taxpayer benefiting from the investment tax benefit to have a clean drug test, was not agreed to by a roll call vote of 24 yeas to 15 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady		X		Mr. Neal	X		
Mr. Johnson		X		Mr. Levin	X		
Mr. Nunes		X		Mr. Lewis	X		
Mr. Tiberi		X		Mr. Doggett	X		
Mr. Reichert		X		Mr. Thompson	X		
Mr. Roskam		X		Mr. Larson	X		
Mr. Buchanan		X		Mr. Blumenauer			
Mr. Smith (NE)		X		Mr. Kind	X		
Ms. Jenkins		X		Mr. Pascrell	X		
Mr. Paulsen		X		Mr. Crowley	X		
Mr. Marchant		X		Mr. Davis	X		
Ms. Black		X		Ms. Sanchez	X		
Mr. Reed		X		Mr. Higgins	X		
Mr. Kelly		X		Ms. Sewell	X		
Mr. Renacci		X		Ms. DelBene	X		
Mr. Meehan		X		Ms. Chu	X		
Ms. Noem		X					
Mr. Holding		X					
Mr. Smith (MO)		X					
Mr. Rice		X					
Mr. Schweikert		X					
Ms. Walorski		X					
Mr. Curbelo		X					
Mr. Bishop		X					

The legislation was ordered favorably transmitted to the House Committee on the Budget as amended by a roll call vote of 24 yeas and 15 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X			Mr. Neal		X	
Mr. Johnson	X			Mr. Levin		X	
Mr. Nunes	X			Mr. Lewis		X	
Mr. Tiberi	X			Mr. Doggett		X	
Mr. Reichert	X			Mr. Thompson		X	
Mr. Roskam	X			Mr. Larson		X	
Mr. Buchanan	X			Mr. Blumenauer			
Mr. Smith (NE)	X			Mr. Kind		X	
Ms. Jenkins	X			Mr. Pascrell		X	
Mr. Paulsen	X			Mr. Crowley		X	
Mr. Marchant	X			Mr. Davis		X	
Ms. Black	X			Ms. Sanchez		X	
Mr. Reed	X			Mr. Higgins		X	
Mr. Kelly	X			Ms. Sewell		X	

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X						
Mr. Holding	X						
Mr. Smith (MO)	X						
Mr. Rice	X						
Mr. Schweikert	X						
Ms. Walorski	X						
Mr. Curbelo	X						
Mr. Bishop	X						

IV. BUDGET EFFECTS OF THE PROVISION

A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the “Repeal of Net Investment Income Tax.”

The budget reconciliation legislative recommendations, as transmitted, are estimated to have the following effects on budget receipts for fiscal years 2016–2025:

By fiscal year, in billions of dollars—											
2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–21	2017–26
–1.5	–10.5	–7.5	–16.7	–17.8	–18.7	–19.7	–20.7	–21.7	–22.7	–54.1	–157.6

NOTE: Details do not add to totals due to rounding.

Pursuant to clause 8 of rule XIII of the Rules of the House of Representatives, the following statement is made by the Joint Committee on Taxation with respect to the provisions of the bill amending the Internal Revenue Code of 1986: the gross budgetary effect (before incorporating macroeconomic effects) in any fiscal year is less than 0.25 percent of the current projected gross domestic product of the United States for that fiscal year; therefore, the bill is not “major legislation” for purposes of requiring that the estimate include the budgetary effects of changes in economic output, employment, capital stock and other macroeconomic variables.

B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES BUDGET AUTHORITY

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the budget reconciliation legislative recommendations involve no new or increased budget authority. The Committee states further that the budget reconciliation legislative recommendations involve no new or increased tax expenditures.

C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, the following statement by the CBO is provided.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

March 13, 2017.

American Health Care Act

*Budget Reconciliation Recommendations of the House Committees
on Ways and Means and Energy and Commerce, March 9, 2017*

SUMMARY

The Concurrent Resolution on the Budget for Fiscal Year 2017 directed the House Committees on Ways and Means and Energy and Commerce to develop legislation to reduce the deficit. The Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have produced an estimate of the budgetary effects of the American Health Care Act, which combines the pieces of legislation approved by the two committees pursuant to that resolution. In consultation with the budget committees, CBO used its March 2016 baseline with adjustments for subsequently enacted legislation, which underlies the resolution, as the benchmark to measure the cost of the legislation.

Effects on the Federal Budget

CBO and JCT estimate that enacting the legislation would reduce federal deficits by \$337 billion over the 2017–2026 period. That total consists of \$323 billion in on-budget savings and \$13 billion in off-budget savings. Outlays would be reduced by \$1.2 trillion over the period, and revenues would be reduced by \$0.9 trillion.

The largest savings would come from reductions in outlays for Medicaid and from the elimination of the Affordable Care Act's (ACA's) subsidies for nongroup health insurance. The largest costs would come from repealing many of the changes the ACA made to the Internal Revenue Code—including an increase in the Hospital Insurance payroll tax rate for high-income taxpayers, a surtax on those taxpayers' net investment income, and annual fees imposed on health insurers—and from the establishment of a new tax credit for health insurance.

Pay-as-you-go procedures apply because enacting the legislation would affect direct spending and revenues. CBO and JCT estimate that enacting the legislation would not increase net direct spending or on-budget deficits by more than \$5 billion in any of the four consecutive 10-year periods beginning in 2027.

Effects on Health Insurance Coverage

To estimate the budgetary effects, CBO and JCT projected how the legislation would change the number of people who obtain federally subsidized health insurance through Medicaid, the nongroup market, and the employment-based market, as well as many other factors.

CBO and JCT estimate that, in 2018, 14 million more people would be uninsured under the legislation than under current law. Most of that increase would stem from repealing the penalties associated with the individual mandate. Some of those people would choose not to have insurance because they chose to be covered by insurance under current law only to avoid paying the penalties, and some people would forgo insurance in response to higher premiums.

Later, following additional changes to subsidies for insurance purchased in the nongroup market and to the Medicaid program, the increase in the number of uninsured people relative to the number under current law would rise to 21 million in 2020 and then to 24 million in 2026. The reductions in insurance coverage between 2018 and 2026 would stem in large part from changes in Medicaid enrollment—because some states would discontinue their expansion of eligibility, some states that would have expanded eligibility in the future would choose not to do so, and per-enrollee spending in the program would be capped. In 2026, an estimated 52 million people would be uninsured, compared with 28 million who would lack insurance that year under current law.

Stability of the Health Insurance Market

Decisions about offering and purchasing health insurance depend on the stability of the health insurance market—that is, on having insurers participating in most areas of the country and on the likelihood of premiums' not rising in an unsustainable spiral. The market for insurance purchased individually (that is, nongroup coverage) would be unstable, for example, if the people who wanted to buy coverage at any offered price would have average health care expenditures so high that offering the insurance would be unprofitable. In CBO and JCT's assessment, however, the nongroup market would probably be stable in most areas under either current law or the legislation.

Under current law, most subsidized enrollees purchasing health insurance coverage in the nongroup market are largely insulated from increases in premiums because their out-of-pocket payments for premiums are based on a percentage of their income; the government pays the difference. The subsidies to purchase coverage combined with the penalties paid by uninsured people stemming from the individual mandate are anticipated to cause sufficient demand for insurance by people with low health care expenditures for the market to be stable.

Under the legislation, in the agencies' view, key factors bringing about market stability include subsidies to purchase insurance, which would maintain sufficient demand for insurance by people with low health care expenditures, and grants to states from the Patient and State Stability Fund, which would reduce the costs to

insurers of people with high health care expenditures. Even though the new tax credits would be structured differently from the current subsidies and would generally be less generous for those receiving subsidies under current law, the other changes would, in the agencies' view, lower average premiums enough to attract a sufficient number of relatively healthy people to stabilize the market.

Effects on Premiums

The legislation would tend to increase average premiums in the nongroup market prior to 2020 and lower average premiums thereafter, relative to projections under current law. In 2018 and 2019, according to CBO and JCT's estimates, average premiums for single policyholders in the nongroup market would be 15 percent to 20 percent higher than under current law, mainly because the individual mandate penalties would be eliminated, inducing fewer comparatively healthy people to sign up.

Starting in 2020, the increase in average premiums from repealing the individual mandate penalties would be more than offset by the combination of several factors that would decrease those premiums: grants to states from the Patient and State Stability Fund (which CBO and JCT expect to largely be used by states to limit the costs to insurers of enrollees with very high claims); the elimination of the requirement for insurers to offer plans covering certain percentages of the cost of covered benefits; and a younger mix of enrollees. By 2026, average premiums for single policyholders in the nongroup market under the legislation would be roughly 10 percent lower than under current law, CBO and JCT estimate.

Although average premiums would increase prior to 2020 and decrease starting in 2020, CBO and JCT estimate that changes in premiums relative to those under current law would differ significantly for people of different ages because of a change in age-rating rules. Under the legislation, insurers would be allowed to generally charge five times more for older enrollees than younger ones rather than three times more as under current law, substantially reducing premiums for young adults and substantially raising premiums for older people.

Uncertainty Surrounding the Estimates

The ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to the changes made by the legislation are all difficult to predict, so the estimates in this report are uncertain. But CBO and JCT have endeavored to develop estimates that are in the middle of the distribution of potential outcomes.

Macroeconomic Effects

Because of the magnitude of its budgetary effects, this legislation is "major legislation," as defined in the rules of the House of Rep-

representatives.¹ Hence, it triggers the requirement that the cost estimate, to the greatest extent practicable, include the budgetary impact of its macroeconomic effects. However, because of the very short time available to prepare this cost estimate, quantifying and incorporating those macroeconomic effects have not been practicable.

Intergovernmental and Private-Sector Mandates

JCT and CBO have reviewed the provisions of the legislation and determined that they would impose no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA).

JCT and CBO have determined that the legislation would impose private-sector mandates as defined in UMRA. On the basis of information from JCT, CBO estimates the aggregate cost of the mandates would exceed the annual threshold established in UMRA for private-sector mandates (\$156 million in 2017, adjusted annually for inflation).

MAJOR PROVISIONS OF THE LEGISLATION

Budgetary effects related to health insurance coverage would stem primarily from the following provisions:

- Eliminating penalties associated with the requirements that most people obtain health insurance coverage and that large employers offer their employees coverage that meets specified standards.
- Reducing the federal matching rate for adults made eligible for Medicaid by the ACA to equal the rate for other enrollees in the state, beginning in 2020.
- Capping the growth in per-enrollee payments for most Medicaid beneficiaries to no more than the medical care component of the consumer price index starting in 2020.
- Repealing current-law subsidies for health insurance coverage obtained through the nongroup market—which include refundable tax credits for premium assistance and subsidies to reduce cost-sharing payments—as well as the Basic Health Program, beginning in 2020.
- Creating a new refundable tax credit for health insurance coverage purchased through the nongroup market beginning in 2020.
- Appropriating funding for grants to states through the Patient and State Stability Fund beginning in 2018.
- Relaxing the current-law requirement that prevents insurers from charging older people premiums that are more than three times larger than the premiums charged to younger people in the nongroup and small-group markets. Unless a state sets a different limit, the legislation would allow insurers to charge older people five times more than younger ones, beginning in 2018.

¹ Cl. 8 of Rule XIII of the Rules of the House of Representatives, H.R. Res. 5, 115th Congress (2017).

- Removing the requirement, beginning in 2020, that insurers who offer plans in the nongroup and small-group markets generally must offer plans that cover at least 60 percent of the cost of covered benefits.
- Requiring insurers to apply a 30 percent surcharge on premiums for people who enroll in insurance in the nongroup or small-group markets if they have been uninsured for more than 63 days within the past year.

Other parts of the legislation would repeal or delay many of the changes the ACA made to the Internal Revenue Code that were not directly related to the law's insurance coverage provisions. Those with the largest budgetary effects include:

- Repealing the surtax on certain high-income taxpayers' net investment income;
- Repealing the increase in the Hospital Insurance payroll tax rate for certain high-income taxpayers;
- Repealing the annual fee on health insurance providers; and
- Delaying when the excise tax imposed on some health insurance plans with high premiums would go into effect.

In addition, the legislation would make several changes to other health-related programs that would have smaller budgetary effects.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

CBO and JCT estimate that, on net, enacting the legislation would decrease federal deficits by \$337 billion over the 2017–2026 period (see Table 1). That change would result from a \$1.2 trillion decrease in direct spending, partially offset by an \$883 billion reduction in revenues.

BASIS OF ESTIMATE

For this estimate, CBO and JCT assume that the legislation will be enacted by May 2017. Costs and savings are measured relative to CBO's March 2016 baseline projections, with adjustments for legislation that was enacted after that baseline was produced.

The largest budgetary effects would stem from provisions in the recommendations from both committees that would affect insurance coverage. Those provisions, taken together, would reduce projected deficits by \$935 billion over the 2017–2026 period. Other provisions would increase deficits by \$599 billion, mostly by reducing tax revenues. All told, deficits would be reduced by \$337 billion over that period, CBO and JCT estimate. (See Table 2 for the estimated budgetary effects of each major provision.)

Budgetary Effects of Health Insurance Coverage Provisions

The \$935 billion in estimated deficit reduction over the 2017–2026 period that would stem from the insurance coverage provisions includes the following amounts (shown in Table 3):

- A reduction of \$880 billion in federal outlays for Medicaid;

- Savings of \$673 billion, mostly stemming from the elimination of the ACA's subsidies for nongroup health insurance—which include refundable tax credits for premium assistance and subsidies to reduce cost-sharing payments—in 2020;
- Savings of \$70 billion mostly associated with shifts in the mix of taxable and nontaxable compensation resulting from net decreases in the number of people estimated to enroll in employment-based health insurance coverage; and
- Savings of \$6 billion from the repeal of a tax credit for certain small employers that provide health insurance to their employees.

Those decreases would be partially offset by:

- A cost of \$361 billion for the new tax credit for health insurance established by the legislation in 2020;
- A reduction in revenues of \$210 billion from eliminating the penalties paid by uninsured people and employers;
- An increase in spending of \$80 billion for the new Patient and State Stability Fund grant program; and
- A net increase in spending of \$43 billion under the Medicare program stemming from changes in payments to hospitals that serve a disproportionate share of low-income patients.

Methodology. The legislation would change the pricing of nongroup insurance and the eligibility for and the amount of subsidies to purchase that insurance. It would also lead to changes in Medicaid eligibility and per capita spending. The legislation's effects on health insurance coverage would depend in part on how responsive individuals are to changes in the prices, after subsidies, they would have to pay for nongroup insurance; on changes in their eligibility for public coverage; and on their underlying desire for such insurance. Effects on coverage would also stem from how responsive firms are to changes in those post subsidy prices and in the attractiveness of other aspects of nongroup alternatives to employment-based insurance.

To capture those complex interactions, CBO uses a microsimulation model to estimate how rates of coverage and sources of insurance would change as a result of alterations in eligibility and subsidies for—and thus the net cost of—various insurance options. Based on survey data, that model incorporates a wide range of information about a representative sample of individuals and families, including their income, employment, health status, and health insurance coverage. The model also incorporates information from the research literature about the responsiveness of individuals and employers to price changes and the responsiveness of individuals to changes in eligibility for public coverage. CBO regularly updates the model so that it incorporates information from the most recent administrative data on insurance coverage and premiums. CBO and JCT use that model—in combination with models of tax revenues, models of Medicaid spending and actions by states, projections of trends in early retirees' health insurance coverage, and other available information—to inform their estimates of the num-

bers of people with certain types of coverage and the associated federal budgetary costs.²

Effects of Repealing Mandate Penalties. Eliminating the penalties associated with two requirements, while keeping the requirements themselves in place, would affect insurance coverage in various ways. Those two requirements are that most people obtain health insurance coverage (also called the individual mandate) and that large employers offer their employees health insurance coverage that meets specified standards (also called the employer mandate). Eliminating their associated penalties would reduce federal revenues starting in 2017, but CBO and JCT estimate that doing so would also substantially reduce the number of people with health insurance coverage and, accordingly, would reduce the costs incurred by the federal government in subsidizing some health insurance coverage. The estimated savings stemming from fewer people enrolling in Medicaid, in health insurance obtained through the nongroup market, and in employment-based health insurance coverage would exceed the estimated loss of revenues from eliminating mandate penalties.

CBO and JCT estimate that repealing the individual mandate penalties would also result in higher health insurance premiums in the nongroup market after 2017.³ Insurers would still be required to provide coverage to any applicant, would not be able to vary premiums to reflect enrollees' health status or to limit coverage of pre-existing medical conditions, and would be limited in how premiums could vary by age. Those features are most attractive to applicants with relatively high expected costs for health care, so CBO and JCT expect that repealing the individual mandate penalties would tend to reduce insurance coverage less among older and less healthy people than among younger and healthier people. Thus, the agencies estimate that repealing those penalties, taken by itself, would increase premiums. Nevertheless, CBO and JCT anticipate that a significant number of relatively healthy people would still purchase insurance in the nongroup market because of the availability of government subsidies.

Major Changes to Medicaid. CBO estimates that several major provisions affecting Medicaid would decrease direct spending by \$880 billion over the 2017–2026 period. That reduction would stem primarily from lower enrollment throughout the period, culminating in 14 million fewer Medicaid enrollees by 2026, a reduction of about 17 percent relative to the number under current law. Some of that decline would be among people who are currently eligible for Medicaid benefits, and some would be among people who CBO projects would be made eligible as a result of state actions in the future under current law (that is, from additional states adopting the optional expansion of eligibility authorized by the ACA). Some decline in spending and enrollment would begin immediately, but most of the changes would begin in 2020, when the legislation would terminate the enhanced federal matching rate for new en-

²For additional information, see Congressional Budget Office, "Methods for Analyzing Health Insurance Coverage" (accessed March 13, 2017), www.cbo.gov/topics/health-care/methods-analyzing-health-insurance-coverage.

³CBO and JCT expect that insurers would not be able to change their 2017 premiums because those premiums have already been set.

rollees under the ACA's expansion of Medicaid and would place a per capita-based cap on the federal government's payments to states for medical assistance provided through Medicaid. By 2026, Medicaid spending would be about 25 percent less than what CBO projects under current law.

Changes Before 2020. Under current law, the penalties associated with the individual mandate apply to some Medicaid-eligible adults and children. (For example, the penalties apply to single individuals with income above about 90 percent of the federal poverty guidelines, also known as the federal poverty level, or FPL). CBO estimates that, without those penalties, fewer people would enroll in Medicaid, including some who are not subject to the penalties but might think they are. Some people might be uncertain about what circumstances trigger the penalty and others might be uncertain about their annual income. The estimated lower enrollment would result in less spending for the program. Those effects on enrollment and spending would continue throughout the 2017–2026 period.

Termination of Enhanced Federal Matching Funds for New Enrollees From Expanding Eligibility for Medicaid. Under current law, states are permitted, but not required, to expand eligibility for Medicaid to adults under 65 whose income is equal to or less than 138 percent of the FPL (referred to here as “newly eligible”). The federal government pays a larger share of the medical costs for those people than it pays for those who were previously eligible. Beginning in 2020, the legislation would reduce the federal matching rate for newly eligible adults from 90 percent of medical costs to the rate for other enrollees in the state. (The federal matching rate for other enrollees ranges from 50 percent to 75 percent, depending on the state, with an average of about 57 percent.) The lower federal matching rate would apply only to those newly enrolled after December 31, 2019.

The 31 states and the District of Columbia that have already expanded Medicaid to the newly eligible cover roughly half of that population nationwide. CBO projects that under current law, additional states will expand their Medicaid programs and that, by 2026, roughly 80 percent of newly eligible people will reside in states that have done so. Under the legislation, largely because states would pay for a greater share of enrollees' costs, CBO expects that no additional states would expand eligibility, thereby reducing both enrollment in and spending for Medicaid. According to CBO's estimates, that effect would be modest in the near term, but by 2026, on an average annual basis, 5 million fewer people would be enrolled in Medicaid than would have been enrolled under current law (see Figure 1).

CBO also anticipates some states that have already expanded their Medicaid programs would no longer offer that coverage, reducing the share of the newly eligible population residing in a state with expanded eligibility to about 30 percent in 2026. That estimate reflects different possible outcomes without any explicit prediction about which states would make which choices. In considering the possible outcomes, CBO took into account several factors: the extent of optional coverage provided to the newly eligible popu-

lation and other groups before the ACA's enactment (as a measure of a state's willingness to provide coverage above statutory minimums), states' ability to bear costs under the legislation, and potential methods to mitigate those costs (such as changes to benefit packages and payment rates). Some states might also begin to take action prior to 2020 in anticipation of future changes that would result from the legislation to avoid abrupt changes to eligibility and other program features. How individual states would ultimately respond is highly uncertain.

Because the lower federal matching rate would apply only to those newly enrolled after December 31, 2019 (or who experience a break in eligibility after that date), CBO estimates that reductions in spending for the newly eligible would increase over several years, as "grandfathered" enrollees would cycle off the program and be replaced by new enrollees. On the basis of historical data (and taking into account the increased frequency of eligibility redeterminations required by the legislation), CBO projects that fewer than one-third of those enrolled as of December 31, 2019, would have maintained continuous eligibility two years later. Under the legislation, the higher federal matching rate would apply for fewer than 5 percent of newly eligible enrollees by the end of 2024, CBO estimates.

Per Capita-Based Cap on Medicaid Payments for Medical Assistance. Under current law, the federal government and state governments share in the financing and administration of Medicaid. In general, states pay health care providers for services to enrollees, and the federal government reimburses states for a percentage of their expenditures. All federal reimbursement for medical services is open-ended, meaning that if a state spends more because enrollment increases or costs per enrollee rise, additional federal payments are automatically generated.

Under the legislation, beginning in 2020, the federal government would establish a limit on the amount of reimbursement it provides to states. That limit would be set by calculating the average per-enrollee cost of medical services for most enrollees who received full Medicaid benefits in 2016 for each state. The Secretary of Health and Human Services would then inflate the average per-enrollee costs for each state by the growth in the consumer price index for medical care services (CPI-M). The final limit on federal reimbursement for each state for 2020 and after would be the average cost per enrollee for five specified groups of enrollees (the elderly, disabled people, children, newly eligible adults, and all other adults), reflecting growth in the CPI-M from 2016 multiplied by the number of enrollees in each category in that year. If a state spent more than the limit on federal reimbursement, the federal government would provide no additional funding to match that spending.

The limit on federal reimbursement would reduce outlays because (after the changes to the Medicaid expansion population have been accounted for) Medicaid spending would grow on a per-enrollee basis at a faster rate than the CPI-M, according to CBO's projections: at an average annual rate of 4.4 percent for Medicaid and 3.7 percent for the CPI-M over the 2017–2026 period. With less federal reimbursement for Medicaid, states would need to de-

cide whether to commit more of their own resources to finance the program at current-law levels or whether to reduce spending by cutting payments to health care providers and health plans, eliminating optional services, restricting eligibility for enrollment, or (to the extent feasible) arriving at more efficient methods for delivering services. CBO anticipates that states would adopt a mix of those approaches, which would result in additional savings to the federal government. (Other provisions affecting Medicaid are discussed below.)

Changes to Subsidies and Market Rules for Nongroup Health Insurance Before 2020. Under the legislation, existing subsidies for health insurance coverage purchased in the nongroup market would largely remain in effect until 2020—but the premium tax credits would differ by the age of the individual in 2019. Aside from the changes in enrollment and premiums as a result of eliminating the individual mandate penalties (mentioned earlier), the other changes discussed in this section would have small effects on coverage and federal subsidies in the nongroup market.

Nongroup Market Subsidies. Subsidies under current law fall into two categories: subsidies to cover a portion of participants' health insurance premiums (which take the form of refundable tax credits) and subsidies to reduce their cost-sharing amounts (out-of-pocket payments required under insurance policies). The first category of subsidies, also called premium tax credits, is generally available to people with income between 100 percent and 400 percent of the FPL, with certain exceptions. The second category, also called cost-sharing subsidies, is available to those who are eligible for premium tax credits, generally have a household income between 100 percent and 250 percent of the FPL, and enroll in an eligible plan.

Under current law, those subsidies can be obtained only by purchasing nongroup coverage through a health insurance marketplace. Under the legislation, premium tax credits—but not cost-sharing subsidies—would also be available for most plans purchased in the nongroup market outside of marketplaces beginning in 2018. However, the tax credits for those plans could not be advanced and could only be claimed on a person's tax return. CBO and JCT estimate that roughly 2 million people who are expected to enroll in plans purchased in the nongroup market outside of marketplaces in 2018 and 2019 under current law would newly receive premium tax credits for that coverage under the legislation.

The premium tax credits would differ by the age of the individual for one year in 2019, while cost-sharing subsidies would remain unchanged prior to 2020. For those with household income exceeding 150 percent of the FPL, the legislation would generally reduce the percentage of income that younger people had to pay toward their premiums and increase that percentage for older people.⁴ CBO and JCT expect that roughly 1 million more people would enroll in cov-

⁴For families, the age of the oldest taxpayer would be used to determine the age-adjusted percentage of income that must be paid toward the premiums. As under current law, the premium tax credits would cover the amount by which the reference premium—that is, the premium for the second-lowest-cost “silver” plan that covers the eligible people in the household in the area in which they reside—exceeds that percentage of income. A silver plan covers about 70 percent of the costs of covered benefits.

erage obtained through the nongroup market as a result of the change in the structure of premium tax credits. That increase would be the net result of higher enrollment among younger people and lower enrollment among older people.

Patient and State Stability Fund Grants. Beginning in 2018 and ending after 2026, the federal government would make a total of \$100 billion in allotments to states that they could use for a variety of purposes, including reducing premiums for insurance in the nongroup market. CBO and JCT estimate that federal outlays for grants from the Patient and State Stability Fund would total \$80 billion over the 2018–2026 period.

By the agencies' estimates, the grants would reduce premiums for insurance in the nongroup market in many states. CBO and JCT expect that states would use those grants mostly to reimburse insurers for some of the costs of enrollees with claims above a threshold. For states that did not develop plans to spend the funds, the federal government would make payments to insurers in the individual market who have enrollees with relatively high claims. Before 2020, CBO expects, the Secretary of Health and Human Services would make payments to insurers on the behalf of most states because most would not have enough time to set up their own programs before insurers had to set premiums for 2018. As a result, CBO estimates that most states would rely on the federal default program for one or more years until they had more time to establish their own programs.

Continuous Coverage Provisions. Insurers would be required to impose a penalty on people who enrolled in insurance in the nongroup or small-group markets if they had been uninsured for more than 63 days within the past year. When they purchased insurance in the nongroup or small-group market, they would be subject to a surcharge equal to 30 percent of their monthly premium for up to 12 months. The requirement would apply to people enrolling during a special enrollment period in 2018 and, beginning in 2019, to people enrolling at any time during the year.

CBO and JCT expect that increasing the future price of insurance through the surcharge for people who do not have continuous coverage would increase the number of people with insurance in 2018 and reduce that number in 2019 and later years. By the agencies' estimates, roughly 1 million people would be induced to purchase insurance in 2018 to avoid possibly having to pay the surcharge in the future. In most years after 2018, however, roughly 2 million fewer people would purchase insurance because they would either have to pay the surcharge or provide documentation about previous health insurance coverage. The people deterred from purchasing coverage would tend to be healthier than those who would not be deterred and would be willing to pay the surcharge.

Age Rating Rules. Beginning in 2018, the legislation would expand the limits on how much insurers in the nongroup and small-group markets can vary premiums on the basis of age. However, CBO and JCT expect that the provision could not be implemented until 2019 because there would be insufficient time for the federal government, states, and insurers to incorporate the changes and

then set premiums for 2018. Under current law, a 64-year-old can generally be charged premiums that cost up to three times as much as those offered to a 21-year-old. Under the legislation, that allowable difference would shift to five times as much unless a state chose otherwise. That change would tend to reduce premiums for younger people and increase premiums for older people.

However, CBO and JCT estimate that the structure of the premium tax credits before 2020 would limit how changes in age rating rules affected the number of people who would enroll in health insurance coverage in the nongroup market. People eligible for subsidies in the nongroup market are now largely insulated from changes in premiums: A person receiving a premium tax credit pays a certain percentage of his or her income toward the reference premium, and the tax credit covers the difference between the premium and that percentage of income. Consequently, despite the changes in premiums for younger and older people, the person's out-of-pocket payments would not be affected much. Therefore, CBO and JCT estimate that the increase in the number of people enrolled in coverage through the nongroup market as a result of changes in age rating rules would be less than 500,000 in 2019 and would be the net result of higher enrollment among younger people and lower enrollment among older people. The small increase would mostly stem from net changes in enrollment among people who had income high enough to be ineligible for subsidies and who would face substantial changes in out-of-pocket payments for premiums.

Changes to Subsidies and Market Rules for Nongroup Health Insurance Beginning in 2020. Beginning in 2020, the current premium tax credits and cost-sharing subsidies would both be repealed. That same year, the legislation would create new refundable tax credits for insurance purchased in the nongroup market. In addition to making the market changes discussed thus far (eliminating mandate penalties, providing grants to states to help stabilize the nongroup market, establishing a requirement for continuous coverage, and changing the age rating rules), the legislation would relax the current requirements about the share of benefits that must be covered by a health insurance plan.

Many rules governing the nongroup market would remain in effect as under current law. For example, insurers would be required to accept all applicants during specified open-enrollment periods, could not vary people's premiums on the basis of their health, and could not restrict coverage of enrollees' preexisting health conditions. Insurers would also still be required to cover specified categories of health care services, and the amount of costs for covered services that enrollees have to pay out of pocket would remain limited to a specified threshold. Prohibitions on annual and lifetime maximum benefits would still apply. Also, the risk adjustment program—which transfers funds from plans that attract a relatively small proportion of high-risk enrollees (people with serious chronic conditions, for example) to plans that attract a relatively large proportion of such people—would remain in place.

Because the new tax credits are designed primarily to be paid in advance on behalf of enrollees to insurers, procedures would need to be in place to enable the Internal Revenue Service and the De-

partment of Health and Human Services to verify that the credits were being paid to eligible insurers who were offering qualified insurance as defined under federal and state law on behalf of eligible enrollees. CBO and JCT's estimates reflect an assumption that adequate resources would be made available through future appropriations to those executive branch agencies to ensure that such systems were put in place in a timely manner. To the extent that they were not, enrollment and compliance could be negatively affected.

Changes to Actuarial Value Requirements. Actuarial value is the percentage of total costs for covered benefits that the plan pays when covering a standard population. Under current law, most plans in the nongroup and small-group markets must have an actuarial value that is in one of four tiers: about 60 percent, 70 percent, 80 percent, or 90 percent. Beginning in 2020, the legislation would repeal those requirements, potentially allowing plans to have an actuarial value below 60 percent. However, plans would still be required to cover 10 categories of health benefits that are defined as "essential" under current law, and the total annual out-of-pocket costs for an enrollee would remain capped. In CBO and JCT's estimation, complying with those two requirements would significantly limit the ability of insurers to design plans with an actuarial value much below 60 percent.

Nevertheless, CBO and JCT estimate that repealing the actuarial value requirements would lower the actuarial value of plans in the nongroup market on average. The requirement that insurers offer both a plan with an actuarial value of 70 percent and one with an actuarial value of 80 percent in order to participate in the marketplace would no longer apply under the legislation. As a result, an insurer could choose to sell only plans with lower actuarial values. Many insurers would find that option attractive because they could offer a plan priced closer to the amount of the premium tax credit so that a younger person would have low out-of-pocket costs for premiums and would be more likely to enroll. Insurers might be less likely to offer plans with high actuarial values out of a fear of attracting a greater proportion of less healthy enrollees to those plans, although the availability of the Patient and State Stability Fund grants in most states would reduce that risk. The continuation of the risk adjustment program could also help limit insurers' costs from high-risk enrollees.

Because of plans' lower average actuarial values, CBO and JCT expect that individuals' cost-sharing payments, including deductibles, in the nongroup market would tend to be higher than those anticipated under current law. In addition, cost-sharing subsidies would be repealed in 2020, significantly increasing out-of-pocket costs for nongroup insurance for many lower-income enrollees. The higher costs would make the plans less attractive than those available under current law to many potential enrollees, especially people who are eligible for the largest subsidies under current law.

Changes in the Ways the Nongroup Market Would Function. Under the legislation, some of the ways that the nongroup market functions would change for consumers. The current actuarial value

requirements help people compare different insurance plans, because all plans in a tier cover the same share of costs, on average. CBO and JCT expect that, under the legislation, plans would be harder to compare, making shopping for a plan on the basis of price more difficult.

Another feature of the nongroup market under current law is that there is one central website through the state or federal marketplace where people can shop for all the plans in their area that are eligible for subsidies. Under the legislation, insurers participating in the nongroup market would no longer have to offer plans through the marketplaces in order for people to receive subsidies toward those plans; therefore, CBO and JCT estimate that fewer would do so. With more plans that are eligible for subsidies offered directly from insurers or directly through agents and brokers and not through the marketplaces' central websites, shopping for and comparing plans could be harder, depending on insurers' decisions about how to market their plans.

Changes in Nongroup Market Subsidies. With the repeal in 2020 of the current premium tax credits and the cost-sharing subsidies, different refundable tax credits for insurance purchased in the nongroup market would become available.⁵ The new tax credits would vary on the basis of age by a factor of 2 to 1: Someone age 60 or older would be eligible for a tax credit of \$4,000, while someone younger than age 30 would be eligible for a tax credit of \$2,000. People would generally be eligible for the full amount of the tax credit if their adjusted gross income was below \$75,000 for a single tax filer and below \$150,000 for joint filers and if they were not eligible for certain other types of insurance coverage.⁶ The credits would phase out for people with income above those thresholds. The tax credits would be refundable if the size of the credit exceeded a person's tax liability. They could also be advanced to insurers on a monthly basis throughout the year on behalf of an enrollee. Finally, tax credits could be used for most health insurance plans purchased through a marketplace or directly from an insurer.

Under current law, the size of the premium tax credit depends on household income and the reference premium in an enrollee's rating area. The enrollee pays a certain percentage of his or her income toward the reference premium, and the size of the subsidy varies by geography and age for a given income level. In that way, the enrollee is insulated from variations in premiums by geography and is also largely insulated from increases in the reference premium. An enrollee would pay the difference between the reference premium and the premium for the plan he or she chose, providing some incentive to choose lower-priced insurance. Beginning in 2020, under the legislation, the size of a premium tax credit would vary with age, rather than with income (except for people with income in the phase-out range) or the amount of the premium. The enrollee would be responsible for any premium above the credit amount. That structure would provide greater incentives for enrollees to choose lower-priced insurance and would mean that people

⁵People would also be able to use the new tax credits toward unsubsidized continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

⁶The tax credits and the income thresholds would both be indexed each year by the consumer price index for all urban consumers plus 1 percentage point.

living in high-cost areas would be responsible for a larger share of the premium.

Under the legislation, some people would be eligible for smaller subsidies than those under current law, and others would be eligible for larger ones. As a result, by CBO and JCT's estimates, the composition of the population purchasing health insurance in the nongroup market under the legislation would differ significantly from that under current law, particularly by income and age.

For many lower-income people, the new tax credits under the legislation would tend to be smaller than the premium tax credits under current law.⁷ In an illustrative example, CBO and JCT estimate that a 21-year-old with income at 175 percent of the FPL in 2026 would be eligible for a premium tax credit of about \$3,400 under current law; the tax credit would fall to about \$2,450 under the legislation (see Table 4). In addition, because cost-sharing subsidies would be eliminated under the legislation, lower-income people's share of medical services paid in the form of deductibles and other cost sharing would increase. As a result, CBO and JCT estimate, fewer lower-income people would obtain coverage through the nongroup market under the legislation than under current law.

Conversely, the tax credits under the legislation would tend to be larger than current-law premium tax credits for many people with higher income—particularly for those with income above 400 percent of the FPL but below the income cap for a full credit, which is set by the legislation at \$75,000 for a single tax filer and \$150,000 for joint filers in 2020. For example, CBO and JCT estimate that a 21-year-old with income at 450 percent of the FPL in 2026 would be ineligible for a credit under current law but newly eligible for a tax credit of about \$2,450 under the legislation. Lower out-of-pocket payments toward premiums would tend to increase enrollment in the nongroup market among higher-income people.

Enacting the legislation would also result in significant changes in the size of subsidies in the nongroup market according to people's age. For example, CBO and JCT estimate that a 21-year-old, 40-year-old, and 64-year-old with income at 175 percent of the FPL in 2026 would all pay roughly \$1,700 toward their reference premium under current law, even though the reference premium for a 64-year-old is three times larger than that for a 21-year-old in most states. Under the legislation, premiums for older people could be five times larger than those for younger people in many states, but the size of the tax credits for older people would only be twice the size of the credits for younger people. Because of that difference in how much the tax credits would cover, CBO and JCT estimate that, under the legislation, a larger share of enrollees in the nongroup market would be younger people and a smaller share would be older people.

According to CBO and JCT's estimates, total federal subsidies for nongroup health insurance would be significantly smaller under the legislation than under current law for two reasons. First, by the agencies' projections, fewer people, on net, would obtain coverage in the nongroup health insurance market under the legisla-

⁷ People with income below 100 percent of the FPL who are ineligible for Medicaid and meet other eligibility criteria would become newly eligible for a premium tax credit under the legislation.

tion. Second, the average subsidy per subsidized enrollee under the legislation would be significantly lower than the average subsidy under current law. In 2020, CBO and JCT estimate, the average subsidy under the legislation would be about 60 percent of the average subsidy under current law. In addition, the average subsidy would grow more slowly under the legislation than under current law. That difference results from the fact that subsidies under current law tend to grow with insurance premiums, whereas subsidies under the legislation would grow more slowly, with the consumer price index for all urban consumers plus 1 percentage point. By 2026, CBO and JCT estimate that the average subsidy under the legislation would be about 50 percent of the average subsidy under current law.

Patient and State Stability Fund Grants. As a condition of the grants, beginning in 2020, states would be required to provide matching funds, which would generally increase from 7 percent of the federal funds provided in 2020 to 50 percent of the federal funds provided in 2026. The agencies expect that the grants' effects on premiums after 2020 would be limited by the share of states that took action and decided to pay the required matching funds in order to receive federal money and by the extent to which states chose to use the money for purposes that did not directly help to lower premiums in the nongroup market. Nevertheless, CBO and JCT estimate that the grants would exert substantial downward pressure on premiums in the nongroup market in 2020 and later years and would help encourage participation in the market by insurers.

Effects of Changes in the Nongroup Market on Employers' Decisions to Offer Coverage. CBO and JCT estimate that, over time, fewer employers would offer health insurance because the legislation would change their incentives to do so. First, the mandate penalties would be eliminated. Second, the tax credits under the legislation, for which people would be ineligible if they had any offer of employment-based insurance, would be available to people with a broader range of incomes than the current tax credits are. That change could make nongroup coverage more attractive to a larger share of employees. Consequently, in CBO and JCT's estimation, some employers would choose not to offer coverage and instead increase other forms of compensation in the belief that nongroup insurance was a close substitute for employment-based coverage for their employees.

However, two factors would partially offset employers' incentives not to offer insurance. First, the average subsidy for those who are eligible would be smaller under the legislation than under current law and would grow more slowly than health care costs over time. Second, CBO and JCT anticipate, nongroup insurance under the legislation would be less attractive to many people with employment-based coverage than under current law because nongroup insurance under the legislation would cover a smaller share of enrollees' expenses, on average, and because shopping for and comparing plans would probably be more difficult. In general, CBO and JCT expect that businesses that decided not to offer insurance coverage under the legislation would have, on average, younger and higher-

income workforces than businesses that choose not to offer insurance under current law.

CBO and JCT expect that employers would adapt slowly to the legislation. Some employers would probably delay making decisions because of uncertainty about the viability of and regulations for the nongroup market and about implementation of the new law.

Market Stability. CBO and JCT anticipate that, under the legislation, the combination of subsidies to purchase nongroup insurance and rules regulating the market would result in a relatively stable nongroup market. That is, most areas of the country would have insurers participating in the nongroup market, and the market would not be subject to an unsustainable spiral of rising premiums. First and most important, a substantial number of relatively healthy (mostly young) people would continue to purchase insurance in the nongroup market because of the availability of government subsidies. Second, grants from the Patient and State Stability Fund would help stabilize premiums and reduce potential losses to insurers from enrollees with very large claims. Finally, in CBO and JCT's judgment, the risk adjustment program would help protect insurers from losses arising from high-risk enrollees. The agencies expect that all of those factors would encourage insurers to continue to participate in the nongroup market.

However, significant changes in nongroup subsidies and market rules would occur each year for the first three years following enactment, which might cause uncertainty for insurers in setting premiums. As a result of the elimination of the individual mandate penalties, CBO and JCT project that nongroup enrollment in 2018 would be smaller than that in 2017 and that the average health status of enrollees would worsen. A small share of that decline in enrollment would be offset by the onetime effect of the continuous coverage provisions, which would somewhat increase enrollment in the nongroup market in 2018 as people anticipated potential surcharges in 2019. Grants from the Patient and State Stability Fund would begin to take effect in 2018 to help mitigate losses and encourage participation by insurers.

The mix of enrollees in 2019 would differ from that in 2018, because the change to age-rating rules would allow older adults to be charged five times as much as younger adults in many states. In addition, there would be a one-year change to the premium tax credits, which CBO and JCT expect would somewhat increase enrollment among younger adults and decrease enrollment among older adults. Although the combined effect of those two changes would reduce the average age and improve the average health of enrollees in the nongroup market, it might be difficult for insurers to set premiums for 2019 using their prior experience in the market.

In 2020, CBO estimates, grants to states from the Patient and State Stability Fund, once fully implemented, would significantly reduce premiums in the nongroup market and encourage participation by insurers. The grants would help to reduce the risk to insurers of offering nongroup insurance. As a result, CBO expects that those grants would contribute substantially to the stability of the nongroup market.

That effect would occur despite the fact that more major changes taking effect in that year would make it difficult for insurers to predict the mix of enrollees on the basis of their recent experience. The new age-based tax credits would be introduced in 2020 and actuarial value requirements would be eliminated. In response, insurers would have the flexibility to sell different types of plans than they do under current law. The nongroup market is expected to be smaller in 2020 than in 2019 but then is expected to grow somewhat over the 2020–2026 period.

Other Budgetary Effects of Health Insurance Coverage Provisions. Because the insurance coverage provisions of the legislation would increase the number of uninsured people and decrease the number of people with Medicaid coverage relative to the numbers under current law, CBO estimates that Medicare spending would increase by \$43 billion over the 2018–2026 period.

Medicare makes additional “disproportionate share hospital” payments to facilities that serve a higher percentage of uninsured patients. Those payments have two components: an increase to the payment rate for each inpatient case and a lump-sum allocation of a pool of funds based on each qualifying hospital’s share of the days of care provided to beneficiaries of Supplemental Security Income and Medicaid.

Under the legislation, the decreased enrollment in Medicaid would slightly reduce the amounts paid to hospitals, CBO estimates. However, the increase in the number of uninsured people would substantially boost the amounts distributed on a lump-sum basis.

Net Effects on Health Insurance Coverage

CBO and JCT expect that under the legislation, the number of people without health insurance coverage would increase but that the increase would be limited initially, because insurers have already set their premiums for the current year and many people have already made their enrollment decisions for the year. However, in 2017, the elimination of the individual mandate penalties would result in about 4 million additional people becoming uninsured (see Table 5).

In 2018, by CBO and JCT’s estimates, about 14 million more people would be uninsured, relative to the number under current law. That increase would consist of about 6 million fewer people with coverage obtained in the nongroup market, roughly 5 million fewer people with coverage under Medicaid, and about 2 million fewer people with employment-based coverage. In 2019, the number of uninsured would grow to 16 million people because of further reductions in Medicaid and nongroup coverage. Most of the reductions in coverage in 2018 and 2019 would stem from repealing the penalties associated with the individual mandate. Some of those people would choose not to have insurance because they choose to be covered by insurance under current law only to avoid paying the penalties. And some people would forgo insurance in response to higher premiums. CBO and JCT estimate that, in total, 41 million people under age 65 would be uninsured in 2018 and 43 million people under age 65 would be uninsured in 2019.

In 2020, according to CBO and JCT's estimates, as a result of the insurance coverage provisions of the legislation, 21 million more nonelderly people in the United States would be without health insurance than under current law. By 2026, that number would total 24 million, CBO and JCT estimate. Specifically:

- Roughly 9 million fewer people would enroll in Medicaid in 2020; that figure would rise to 14 million in 2026, as states that expanded eligibility for Medicaid discontinued doing so, as states projected to expand Medicaid in the future chose not to do so, and as the cap on per-enrollee spending took effect.
- Roughly 9 million fewer people, on net, would obtain coverage through the nongroup market in 2020; that number would fall to 2 million in 2026. The reduction in enrollment in the nongroup market would shrink over the 2020–2026 period because people would gain experience with the new structure of the tax credits and some employers would respond to those tax credits by declining to offer insurance to their employees.
- Roughly 2 million fewer people, on net, would enroll in employment-based coverage in 2020, and that number would grow to roughly 7 million in 2026. Part of that net reduction in employment-based coverage would occur because fewer employees would take up the offer of such coverage in the absence of the individual mandate penalties. In addition, CBO and JCT expect that, over time, fewer employers would offer health insurance to their workers.

CBO and JCT estimate that 48 million people under age 65, or roughly 17 percent of the nonelderly population, would be uninsured in 2020 if the legislation was enacted. That figure would grow to 52 million, or roughly 19 percent of the nonelderly population, in 2026. (That figure is currently about 10 percent and is projected to remain at that level in each year through 2026 under current law.) Although the agencies expect that the legislation would increase the number of uninsured broadly, the increase would be disproportionately larger among older people with lower income; in particular, people between 50 and 64 years old with income of less than 200 percent of the FPL would make up a larger share of the uninsured (see Figure 2).

Net Effects on Health Insurance Premiums

The legislation would tend to increase average premiums in the nongroup market prior to 2020 and lower average premiums thereafter, relative to the outcomes under current law. (This discussion is focused on premiums before any applicable tax credits and before any surcharges for not maintaining continuous coverage.)

In 2018 and 2019, according to CBO and JCT's estimates, average premiums for single policyholders in the nongroup market would be 15 percent to 20 percent higher than under current law mainly because of the elimination of the individual mandate penalties. Eliminating those penalties would markedly reduce enrollment in the nongroup market and increase the share of enrollees who would be less healthy. CBO and JCT expect that grants from the Patient and State Stability Fund would largely be used for re-

insurance programs, particularly in 2018 and 2019, when many states would rely on the federal default before establishing their own programs and, as explained earlier, that those payments would help lower premiums in the nongroup market. The agencies estimate that program would have a relatively small effect on premiums in 2018 because there would not be much time between enactment of the legislation and insurers' deadlines for setting premiums for 2018. By 2019, however, in CBO and JCT's judgment, the Patient and State Stability Fund would have the effect of somewhat moderating the increases in average premiums in the nongroup market resulting from the legislation.

Starting in 2020, the increase in average premiums from repealing the individual mandate penalties would be more than offset by the combination of three main factors. First, the mix of people enrolled in coverage obtained in the nongroup market is anticipated to be younger, on average, than the mix under current law. Second, premiums, on average, are estimated to fall because of the elimination of actuarial value requirements, which would result in plans that cover a lower share of health care costs, on average. Third, reinsurance programs supported by the Patient and State Stability Fund are estimated to reduce premiums. If those funds were devoted to other purposes, then premium reductions would be smaller. By 2026, average premiums for single policyholders in the nongroup market under the legislation would be roughly 10 percent lower than the estimates under current law.

The changes in premiums would vary for people of different ages. The change in age-rating rules, effective in 2019, would directly change the premiums faced by different age groups, substantially reducing premiums for young adults and raising premiums for older people. By 2026, CBO and JCT project, premiums in the nongroup market would be 20 percent to 25 percent lower for a 21-year-old and 8 percent to 10 percent lower for a 40-year-old—but 20 percent to 25 percent higher for a 64-year-old.

Revenue Effects of Other Provisions

JCT estimates that the legislation would reduce revenues by \$592 billion over the 2017–2026 period as a result of provisions that would repeal many of the revenue-related provisions of the ACA (apart from provisions related to health insurance coverage discussed above). Those with the most significant budgetary effects include an increase in the Hospital Insurance payroll tax rate for high-income taxpayers, a surtax on those taxpayers' net investment income, and annual fees imposed on health insurers.⁸

Direct Spending Effects of Other Provisions

The legislation would also make changes to spending for other federal health care programs. CBO and JCT estimate that those provisions would increase direct spending by about \$7 billion over the 2017–2026 period.

⁸JCT published 10 documents (JCX-7–17 through JCX-16–17) on March 7, 2017, relating to the legislation. For more information, see www.jct.gov/publications.html.

Prevention and Public Health Fund. The legislation would, beginning in fiscal year 2019, repeal the provision that established the Prevention and Public Health Fund and rescind all unobligated balances. The Department of Health and Human Services awards grants through the fund to public and private entities to carry out prevention, wellness, and public health activities. Funding under current law is projected to be \$1 billion in 2017 and to rise to \$2 billion in 2025 and each year thereafter. CBO estimates that eliminating that funding would reduce direct spending by \$9 billion over the 2017–2026 period.

Community Health Center Program. The legislation would increase the funds available to the Community Health Center Program, which provides grant funds to health centers that offer primary and preventive care to patients regardless of their ability to pay. Under current law, the program will receive about \$4 billion in fiscal year 2017. The legislation would increase funding for the program by \$422 million in fiscal year 2017. CBO estimates that implementing the provision would increase direct spending by \$422 million over the 2017–2026 period.

Provision Affecting Planned Parenthood. For a one-year period following enactment, the legislation would prevent federal funds from being made available to an entity (including its affiliates, subsidiaries, successors, and clinics) if it is:

- A nonprofit organization described in section 501(c)(3) of the Internal Revenue Code and exempt from tax under section 501(a) of the code;
- An essential community provider that is primarily engaged in providing family planning and reproductive health services and related medical care;
- An entity that provides abortions—except in instances in which the pregnancy is the result of an act of rape or incest or the woman’s life is in danger; and
- An entity that had expenditures under the Medicaid program that exceeded \$350 million in fiscal year 2014.

CBO expects that, according to those criteria, only Planned Parenthood Federation of America and its affiliates and clinics would be affected. Most federal funds received by such entities come from payments for services provided to enrollees in states’ Medicaid programs. CBO estimates that the prohibition would reduce direct spending by \$178 million in 2017 and by \$234 million over the 2017–2026 period. Those savings would be partially offset by increased spending for other Medicaid services, as discussed below.

To the extent that there would be reductions in access to care under the legislation, they would affect services that help women avert pregnancies. The people most likely to experience reduced access to care would probably reside in areas without other health care clinics or medical practitioners who serve low-income populations. CBO projects that about 15 percent of those people would lose access to care.

The government would incur some costs for Medicaid beneficiaries currently served by affected entities because the costs of

about 45 percent of all births are paid for by the Medicaid program. CBO estimates that the additional births stemming from the reduced access under the legislation would add to federal spending for Medicaid. In addition, some of those children would themselves qualify for Medicaid and possibly for other federal programs. By CBO's estimates, in the one-year period in which federal funds for Planned Parenthood would be prohibited under the legislation, the number of births in the Medicaid program would increase by several thousand, increasing direct spending for Medicaid by \$21 million in 2017 and by \$77 million over the 2017–2026 period. Overall, with those costs netted against the savings estimated above, implementing the provision would reduce direct spending by \$156 million over the 2017–2026 period, CBO estimates.

Repeal of Medicaid Provisions. Under current law, states can elect the Community First Choice option, allowing them to receive a 6 percentage-point increase in their federal matching rate for some services provided by home and community-based attendants to certain Medicaid recipients. The legislation would terminate the increase in the federal matching funds beginning in calendar year 2020, which would decrease direct spending by about \$12 billion over the next 10 years.

Repeal of Reductions to Allotments for Disproportionate Share Hospitals. Under current law, Medicaid allotments to states for payments to hospitals that treat a disproportionate share of uninsured and Medicaid patients are to be cut significantly in each year from 2018 to 2025. The cuts are currently scheduled to be \$2 billion in 2018 and to increase each year until they reach \$8 billion in 2024 and 2025. The legislation would eliminate those cuts for states that have not expanded Medicaid under the ACA starting in 2018 and for the remaining states starting in 2020, boosting outlays by \$31 billion over the next 10 years.

Safety Net Funding for States That Did Not Expand Medicaid. The legislation would provide \$2 billion in funding in each year from 2018 to 2021 to states that did not expand Medicaid eligibility under the ACA. Those states could use the funding, within limits, to supplement payments to providers that treat Medicaid enrollees. Such payments to providers would not be subject to the per capita caps also established by the proposed legislation. Any states that chose to expand Medicaid coverage as of July 1 of each year from 2017 through 2020 would lose access to the funding available under this provision in the following year and thereafter. CBO estimates that this provision would increase direct spending by \$8 billion over the 2017–2026 period.

Reductions to States' Medicaid Costs. The legislation would make a number of additional changes to the Medicaid program, including these:

- Requiring states to treat lottery winnings and certain other income as income for purposes of determining eligibility;
- Decreasing the period when Medicaid benefits may be covered retroactively from up to three months before a recipient's application to the first of the month in which a recipient makes an application;

- Eliminating federal payments to states for Medicaid services provided to applicants who did not provide satisfactory evidence of citizenship or nationality during a reasonable opportunity period; and
- Eliminating states' option to increase the amount of allowable home equity from \$500,000 to \$750,000 for individuals applying for Medicaid coverage of long-term services and supports.

Together, CBO estimates, those changes would decrease direct spending by about \$7 billion over the 2017–2026 period.

Changes in Spending Subject to Appropriation

CBO has not completed an estimate of the potential impact of the legislation on discretionary spending, which would be subject to future appropriation action.

UNCERTAINTY SURROUNDING THE ESTIMATES

CBO and JCT considered the potential responses of many parties that would be affected by the legislation, including these:

- Federal agencies—which would need to implement major changes in the regulation of the health care system and administration of new subsidy structures and eligibility verification systems in a short time frame;
- States—which would need to decide how to use Patient and State Stability Fund grants, whether to pass new laws affecting the nongroup market, how to respond to the reduction in the federal matching rate for certain Medicaid enrollees, how to respond to constraints from the cap on Medicaid payments, and how to provide information to the federal government about insurers and enrollees;
- Insurers—who would need to decide about the extent of their participation in the insurance market and what types of plans to sell in the face of different market rules and federal subsidies;
- Employers—who would need to decide whether to offer insurance given the different federal subsidies and insurance products available to their employees;
- Individuals—who would make decisions about health insurance in the context of different premiums, subsidies, and penalties than those under current law; and
- Doctors and hospitals—who would need to negotiate contracts with insurers in a new regulatory environment.

Each of those responses is difficult to predict. Moreover, the responses would depend upon how the provisions in the legislation were implemented, such as whether advance payments of the new tax credits were made reliably. And flaws in the determination of eligibility, for instance, could keep subsidies from people who were eligible or provide them to people who were not.

In addition, CBO and JCT's projections under current law itself are inexact, which could also affect the estimated effects. For example, enrollment in the marketplaces under current law could be

lower than is projected, which would tend to decrease the budgetary savings of the legislation. Alternatively, the average subsidy per enrollee under current law could be higher than is projected, which would tend to increase the budgetary savings of the legislation.

CBO and JCT have endeavored to develop estimates that are in the middle of the distribution of potential outcomes. One way to assess the range of uncertainty around the estimated effects of the legislation is to compare previous projections with actual results. For example, some aspects of CBO and JCT's projections of health insurance coverage and related spending made in July 2012 (after the Supreme Court issued a decision that essentially made the expansion of the Medicaid program under the ACA an option for states) can be compared with actual results for 2016. Projected spending on people made eligible for Medicaid because of the ACA was about 60 percent of the actual amount. The number of people predicted in 2012 to purchase insurance through the marketplaces in 2016 was more than twice the actual number. The decline in the number of insured people from 2012 to 2016 was projected to be 23 million, and the decline measured in the National Health Interview Survey turned out to be 20 million. CBO and JCT have continued to learn from experience with the ACA and have endeavored to use that experience to improve their modeling.

That comparison of projections with actual results and the great uncertainties surrounding the actions of the many parties that would be affected by the legislation suggest that outcomes of the legislation could differ substantially from some of the estimates provided here. Nevertheless, CBO and JCT are confident about the direction of certain effects of the legislation. For example, spending on Medicaid would almost surely be lower than under current law. The cost of the new tax credit would probably be lower than the cost of the subsidies for coverage through marketplaces under current law. And the number of uninsured people under the legislation would almost surely be greater than under current law.

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than \$5 billion in any of the four consecutive 10-year periods beginning in 2027.

MANDATES ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

JCT and CBO reviewed the provisions of the legislation and determined that they would impose no intergovernmental mandates as defined in the Unfunded Mandates Reform Act. For large entitlement programs like Medicaid, UMRA defines an increase in the stringency of conditions or a cap on federal funding as an intergovernmental mandate if the affected governments lack authority to offset those costs while continuing to provide required services. As discussed earlier in this estimate, the legislation would eliminate the enhanced federal matching rate for some future enrollees, establish new per capita caps in the Medicaid program, and make

other changes that would affect Medicaid spending—some of which would provide additional assistance to states.

On net, CBO estimates that states would see an overall decrease in federal assistance, as reflected in estimates of federal savings in the Medicaid program. In response to the caps and other changes, CBO anticipates that states could use existing flexibility allowed in the Medicaid program and additional authorities provided by the legislation to cut payments to health care providers and health plans, eliminate optional services, restrict eligibility for enrollment, or (to the extent feasible) change the way services are delivered to save costs. Because flexibility in the program would allow states to make such changes and still provide statutorily required services, the per capita caps and other changes in Medicaid would not impose intergovernmental mandates as defined in UMRA.

MANDATES ON THE PRIVATE SECTOR

JCT and CBO have determined that the legislation would impose private-sector mandates as defined in UMRA. On the basis of information from JCT, CBO estimates that the aggregate direct cost of the mandates imposed by the legislation would exceed the annual threshold established in UMRA for private-sector mandates (\$156 million in 2017, adjusted annually for inflation).

The tax provisions of the legislation contain two mandates. Specifically, the legislation would recapture excess advance payments of premium tax credits (so that the full amount of excess advance payments is treated as an additional tax liability for the individual) and repeal the small business (health insurance) tax credit.

The nontax provisions of the legislation would impose a private-sector mandate as defined in UMRA on insurers that offer health insurance coverage in the individual or small-group market. The legislation would require those insurers to charge a penalty equal to 30 percent of the monthly premium for a period of 12 months to individuals who enroll in insurance in a given year after having allowed their health insurance to lapse for more than 63 days during the previous year. CBO estimates that the costs of complying with the mandate would be largely offset by the penalties insurers would collect.

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TABLE 1.—SUMMARY OF THE DIRECT SPENDING AND REVENUE EFFECTS OF THE AHCA, THE BUDGET RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEES ON WAYS AND MEANS AND ENERGY AND COMMERCE, MARCH 9, 2017

	[Billions of dollars, by fiscal year]										
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
CHANGES IN DIRECT SPENDING^a											
Coverage Provisions:											
Estimated Budget Authority	–6.6	–12.5	–22.9	–97.6	–139.1	–157.4	–173.8	–186.9	–199.4	–210.5	–278.6
Estimated Outlays	–6.6	–27.5	–25.6	–92.5	–138.6	–158.5	–175.2	–188.5	–201.3	–212.0	–290.7
Non Coverage Provisions:											
Estimated Budget Authority	0.3	–0.5	–0.7	0.6	1.7	–0.2	1.0	1.1	0.7	0.0	1.3
Estimated Outlays	–0.1	0.3	–0.1	0.8	1.8	0.5	0.8	1.5	1.3	0.3	2.7
Total Changes in Direct Spending:											
Estimated Budget Authority	–6.3	–13.0	–23.6	–97.1	–137.4	–157.6	–172.8	–185.8	–198.7	–210.5	–277.4
Estimated Outlays	–6.7	–27.2	–25.7	–91.7	–136.9	–158.0	–174.3	–187.0	–200.0	–211.7	–288.1
CHANGES IN REVENUES^b											
Coverage Provisions	–3.8	–13.7	–16.8	–25.5	–33.6	–36.4	–38.9	–40.4	–41.0	–40.7	–290.9
Non Coverage Provisions	–2.1	–37.5	–41.8	–57.6	–65.1	–70.2	–76.0	–83.1	–79.7	–78.7	–591.9
Total Changes in Revenues	–5.9	–51.2	–58.6	–83.1	–98.7	–106.6	–114.9	–123.5	–120.6	–119.4	–882.8
INCREASE OR DECREASE (–) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING OR REVENUES											
Net Increase or Decrease (–) in the Deficit	–0.8	24.0	33.0	–8.6	–38.2	–51.3	–59.4	–63.5	–79.4	–92.4	9.4

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: The costs of this legislation fall within budget function 550 (health), 570 (Medicare), 600 (Income Security), and 650 (Social Security).

AHCA = American Health Care Act; numbers may not add up to totals because of rounding.

^a For outlays, a positive number indicates an increase (adding to the deficit) and a negative number indicates a decrease (reducing the deficit).

^b For revenues, a positive number indicates an increase (adding to the deficit) and a negative number indicates a decrease (reducing the deficit).

TABLE 2.—ESTIMATE OF THE DIRECT SPENDING AND REVENUE EFFECTS OF THE AHCA, THE BUDGET RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEES ON WAYS AND MEANS AND ENERGY AND COMMERCE, MARCH 9, 2017

	[Billions of dollars, by fiscal year]										
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2026
CHANGES IN DIRECT SPENDING^a											
Coverage Provisions:											
Estimated Budget Authority	–6.6	–12.5	–22.9	–97.6	–139.1	–157.4	–173.8	–186.9	–199.4	–210.5	–278.6
Estimated Outlays	–6.6	–27.5	–25.6	–92.5	–138.6	–158.5	–175.2	–188.5	–201.3	–212.0	–290.7
Non Coverage Provisions:											
Estimated Budget Authority	0.3	–0.5	–0.7	0.6	1.7	–0.2	1.0	1.1	0.7	0.0	1.3
Estimated Outlays	–0.1	0.3	–0.1	0.8	1.8	0.5	0.8	1.5	1.3	0.3	2.7
Total Changes in Direct Spending:											
Estimated Budget Authority	–6.3	–13.0	–23.6	–97.1	–137.4	–157.6	–172.8	–185.8	–198.7	–210.5	–277.4
Estimated Outlays	–6.7	–27.2	–25.7	–91.7	–136.9	–158.0	–174.3	–187.0	–200.0	–211.7	–288.1
CHANGES IN REVENUES^b											
Coverage Provisions	–3.8	–13.7	–16.8	–25.5	–33.6	–36.4	–38.9	–40.4	–41.0	–40.7	–290.9
Non Coverage Provisions	–2.1	–37.5	–41.8	–57.6	–65.1	–70.2	–76.0	–83.1	–79.7	–78.7	–591.9
Total Changes in Revenues	–5.9	–51.2	–58.6	–83.1	–98.7	–106.6	–114.9	–123.5	–120.6	–119.4	–882.8
INCREASE OR DECREASE (–) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING OR REVENUES											
Net Increase or Decrease (–) in the Deficit	–0.8	24.0	33.0	–8.6	–38.2	–51.3	–59.4	–63.5	–79.4	–92.4	9.4

Coverage Provisions:

Estimated Budget Authority

TABLE 2.—ESTIMATE OF THE DIRECT SPENDING AND REVENUE EFFECTS OF THE AHCA, THE BUDGET RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEES ON WAYS AND MEANS AND ENERGY AND COMMERCE, MARCH 9, 2017—Continued

[Billions of dollars, by fiscal year]

[illegible]

[illegible]

TABLE 2.—ESTIMATE OF THE DIRECT SPENDING AND REVENUE EFFECTS OF THE AHCA, THE BUDGET RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEES ON WAYS AND MEANS AND ENERGY AND COMMERCE, MARCH 9, 2017—Continued

(Billions of dollars, by fiscal year)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2021	2017–2026
On-Budget	-4.5	-17.0	-19.9	-27.6	-35.5	-38.4	-41.7	-44.7	-46.7	-48.0	-104.5	-324.2
Off-Budget	0.7	3.3	3.1	2.0	1.9	2.0	2.8	4.3	5.8	7.3	11.1	33.3
Recapture Excess Advance Payments of Premium Tax Credits	0	0.6	0.7	0.5	0	0	0	0	0	0	1.8	1.8
Additional Modifications to Premium Tax Credit					[Included in estimate of coverage provisions]							
Premium Tax Credit					[Included in estimate of coverage provisions]							
Small Business Tax Credit					[Included in estimate of coverage provisions]							
Individual Mandate					[Included in estimate of coverage provisions]							
Employer Mandate					[Included in estimate of coverage provisions]							
Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits ^d	0	0	0	-3.4	-6.9	-8.7	-10.7	-13.6	-5.5	0	-10.3	-48.7
Repeal of Tax on Over-the-Counter Medications	0	-0.4	-0.5	-0.6	-0.6	-0.6	-0.6	-0.7	-0.7	-0.7	-2.1	-5.5
Repeal of Increase of Tax on Health Savings	0	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	-0.1
Repeal of Limitations on Contributions to Flexible Spending Accounts	0	-0.3	-1.2	-1.6	-1.7	-1.8	-2.2	-2.6	-3.3	-4.1	-4.7	-18.6
Repeal of Tax on Prescription Medications	0	-3.1	-2.7	-2.7	-2.7	-2.7	-2.7	-2.7	-2.7	-2.7	-11.2	-24.8
Repeal of Medical Device Excise Tax	0	-1.4	-1.9	-2.0	-2.1	-2.2	-2.3	-2.4	-2.6	-2.7	-7.4	-19.6
Repeal of Health Insurance Tax	0	-12.8	-13.5	-14.3	-15.1	-15.9	-16.8	-17.8	-18.7	-19.7	-55.7	-144.7
Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy	0	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.6	-1.7
Repeal of Increase in Income Threshold for Determining Medical Care Deduction	-0.2	-2.0	-3.2	-3.4	-3.6	-3.9	-4.2	-4.5	-4.8	-5.1	-12.4	-34.9
Repeal of Medicare Tax Increase	-0.4	-6.5	-10.1	-11.4	-12.3	-13.2	-14.1	-15.2	-16.5	-17.6	-40.8	-117.3
Refundable Tax Credit for Health Insurance					[Included in estimate of coverage provisions]							
Maximum Contribution Limit to Health Savings	0	-1.0	-1.6	-1.7	-1.9	-2.1	-2.3	-2.5	-2.7	-2.9	-6.2	-18.6
Allow Both Spouses to Make Catch-up Contributions to the Same Health Savings Account	0	(*)	(*)	(*)	(*)	(*)	(*)	(*)	-0.1	-0.1	-0.1	-0.4
Special Rule for Certain Medical Expenses Incurred Before Establishment of Health Savings	0	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	-0.1	-0.2
Repeal of Tanning Tax	0	(*)	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.6
Repeal of Net Investment Tax	-1.5	-10.5	-7.5	-16.7	-17.8	-18.7	-19.7	-20.7	-21.7	-22.7	-54.1	-157.6
Remuneration	0	(*)	(*)	(*)	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.4
Total Changes in Revenues	-5.9	-51.2	-58.6	-83.1	-98.7	-106.6	-114.9	-123.5	-120.6	-119.4	-297.6	-882.8
On-Budget	-6.6	-53.8	-60.8	-83.3	-98.0	-105.5	-114.0	-123.2	-123.3	-124.7	-302.7	-893.5
Off-Budget	0.7	2.6	2.2	0.2	-0.7	-1.2	-1.0	-0.3	2.7	5.3	5.0	10.7
INCREASE OR DECREASE (—) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING OR REVENUES												
Net Increase or Decrease (—) in the Deficit	-0.8	24.0	33.0	-8.6	-38.2	-51.3	-59.4	-63.5	-79.4	-92.4	9.4	-336.5
On-Budget	(*)	26.6	35.1	-8.4	-38.8	-52.3	-59.9	-63.2	-76.0	-86.4	14.5	-323.3

Off-Budget -0.7 -2.6 -2.2 -0.2 0.6 0.9 0.5 -0.3 -3.3 -5.9 -5.1 -13.2

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: The costs of this legislation fall within budget function 550 (health), 570 (Medicare), 600 (Income Security), and 650 (Social Security).

Numbers may not add up to totals because of rounding; DSH = Disproportionate Share Hospital; AHCA = American Health Care Act;

* = an increase or decrease between zero and \$50 million.

^a For outlays, a positive number indicates an increase (adding to the deficit) and a negative number indicates a decrease (reducing the deficit).

^b Estimate interacts with the provision related to the Per Capita Allotment for Medical Assistance.

^c For revenues, a positive number indicates an increase (reducing the deficit) and a negative number indicates a decrease (adding to the deficit).

^d This estimate does not include effects of interactions with other subsidies; those effects are included in estimates of other relevant provisions.

TABLE 3.—NET BUDGETARY EFFECTS OF THE INSURANCE COVERAGE PROVISIONS OF THE AHCA

(Billions of dollars, by fiscal year)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total 2017–2026
Medicaid Outlays	-3	-18	-26	-68	-94	-111	-124	-135	-146	-155	-880
Subsidies for Coverage Through Marketplaces and Related Spending and Revenues ^{a,b} ..	-5	-11	-16	-62	-87	-91	-95	-99	-102	-106	-673
Small-Employer Tax Credits ^{b,c}	(*)	(*)	(*)	(*)	-1	-1	-1	-1	-1	-1	-6
Tax Credits for Nongroup Insurance ^{b,d}	0	0	0	30	44	47	52	58	63	68	361
Penalty Payments by Employers ^e	2	16	20	15	16	18	19	20	22	23	171
Penalty Payments by Uninsured People	3	3	3	3	4	4	4	4	4	5	38
Patient and State Stability Fund Grants	0	0	0	12	15	9	9	8	8	8	80
Medicare ^e	0	1	3	4	6	6	6	6	6	6	43
Other Effects on Revenues and Outlays ^{d,f}	-1	-5	-5	-4	-4	-4	-6	-10	-14	-18	-70
Total Effect on the Deficit	-3	-14	-9	-67	-105	-122	-136	-148	-160	-171	-935
Memorandum:											
Decreases in Mandatory Spending	-7	-27	-26	-93	-139	-158	-175	-188	-201	-212	-1,226
Decreases in Revenues	-4	-14	-17	-26	-34	-36	-39	-40	-41	-41	-291

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Except in the memorandum lines, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

Numbers may not add up to totals because of rounding; AHCA = American Health Care Act; * = between -\$500 million and zero.

^a Related spending and revenues include spending for the Basic Health Program and net spending and revenues for risk adjustment.

^b Includes effects on outlays and on revenues.

^c Effects on the deficit include the associated effects of changes in taxable compensation on revenues.

^d Includes costs for a new tax credit for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

^e Effects arise mostly from changes in Disproportionate Share Hospital payments.

^f Consists mainly of the effects of changes in taxable compensation on revenues. CBO also estimates that outlays for Social Security benefits would decrease by about \$3 billion over the 2017–2026 period.

TABLE 4.—ILLUSTRATIVE EXAMPLE OF SUBSIDIES FOR NONGROUP HEALTH INSURANCE
UNDER CURRENT LAW AND THE AHCA, 2026

[Dollars]

	Premium ^a	Premium tax credit ^b	Net premium paid	Actuarial value of plan after cost-sharing subsidies (percent) ^c
SINGLE INDIVIDUAL WITH ANNUAL INCOME OF \$26,500 (175 PERCENT OF FPL) ^d				
Current Law:				
21 years old	5,100	3,400	1,700	87
40 years old	6,500	4,800	1,700	
64 years old	15,300	13,600	1,700	
AHCA:				
21 years old	3,900	2,450	1,450	65
40 years old	6,050	3,650	2,400	
64 years old	19,500	4,900	14,600	
SINGLE INDIVIDUAL WITH ANNUAL INCOME OF \$68,200 (450 PERCENT OF FPL) ^d				
Current Law:				
21 years old	5,100	0	5,100	70
40 years old	6,500	0	6,500	
64 years old	15,300	0	15,300	
AHCA:				
21 years old	3,900	2,450	1,450	65
40 years old	6,050	3,650	2,400	
64 years old	19,500	4,900	14,600	

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

All dollar figures have been rounded to the nearest \$50; AHCA = American Health Care Act; FPL = federal poverty level.

^a For this illustration, CBO projected the average national premiums for a 21-year-old in the nongroup health insurance market in 2026 both under current law and under the AHCA. On the basis of those amounts, CBO calculated premiums for a 40-year-old and a 64-year-old, assuming that the person lives in a state that uses the federal default age-rating methodology, which limits variation of premiums to a ratio of 3 to 1 for adults under current law and 5 to 1 for adults under the AHCA. CBO projects that, under current law, most states will use the default 3-to-1 age-rating curve; under the AHCA, CBO projects, most would use an age-rating curve with a maximum ratio of 5 to 1.

^b Under current law, premium tax credits are calculated as the difference between the reference premium and a specified percentage of income for a person with income at a given percentage of the FPL. The reference premium is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which the person resides. A silver plan covers about 70 percent of the costs of covered benefits. CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026 for someone with income at 175 percent of the FPL takes into account the probability, estimated in CBO's March 2016 baseline, that additional indexing may apply. Under the AHCA, the premium tax credits offered for nongroup coverage would be indexed to the consumer price index for all urban consumers plus 1 percentage point. In 2026, CBO projects, those tax credits would be about 22 percent higher than the amounts specified in 2020.

^c The actuarial value of a plan is the percentage of costs for covered services that the plan pays. Cost-sharing subsidies are payments made by the federal government to insurers that reduce the cost-sharing amounts (out-of-pocket payments required under insurance policies) for covered people whose income is generally between 100 percent and 250 percent of the FPL. The cost-sharing subsidy amounts in this example would range from \$1,100 for a 21-year-old with income at 175 percent of the FPL to \$3,350 for a 64-year-old at the same income level. Under current law, cost-sharing subsidies have the effect of increasing the actuarial value of the plan from 70 percent for a typical silver plan to 94 percent for people whose income is between 100 percent and 149 percent of the FPL; 87 percent for people between 150 percent and 199 percent of the FPL; and 73 percent for people between 200 percent and 249 percent of the FPL. People whose income is 250 percent of the FPL or more would receive a standard 70 percent actuarial value when purchasing a silver plan. CBO projects that, under the AHCA, the elimination of required actuarial values and the structure of new tax credits would, by 2026, result in a reduction to about 65 percent in the average actuarial value of plans purchased in the nongroup market.

^d Income levels reflect modified adjusted gross income, which equals adjusted gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and income of dependent filers. CBO projects that in 2026, a modified adjusted gross income of \$26,500 would equal 175 percent of the FPL and an income of \$68,200 would equal 450 percent of the FPL.

TABLE 5.—EFFECTS OF THE AHCA ON HEALTH INSURANCE COVERAGE
FOR PEOPLE UNDER AGE 65

[Millions of people, by calendar year]

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Population Under Age 65	273	274	275	276	276	277	278	279	279	280
Uninsured Under Current Law	26	26	27	27	27	27	27	28	28	28
Change in Coverage Under the AHCA:										
Medicaid ^a	-1	-5	-6	-9	-12	-13	-13	-14	-14	-14
Nongroup coverage, including marketplaces ^b	-2	-6	-7	-9	-8	-8	-6	-5	-4	-2
Employment-based coverage	-1	-2	-2	-2	-2	-2	-3	-5	-5	-7
Other coverage ^c	(*)	(*)	(*)	-1	-1	-1	-1	-1	-1	-1
Uninsured	4	14	16	21	23	23	23	24	24	24
Uninsured Under the AHCA	31	41	43	48	50	50	51	51	51	52

TABLE 5.—EFFECTS OF THE AHCA ON HEALTH INSURANCE COVERAGE
FOR PEOPLE UNDER AGE 65—Continued

[Millions of people, by calendar year]

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Percentage of the Population Under Age 65 With Insurance Under the AHCA:										
Including all U.S. residents	89	85	84	83	82	82	82	82	82	81
Excluding unauthorized immigrants	91	87	87	85	84	84	84	84	84	84

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. They reflect average enrollment over the course of a year among noninstitutionalized civilian residents of the 50 states and the District of Columbia who are under the age of 65, and they include spouses and dependents covered under family policies.

AHCA = American Health Care Act; * = a reduction that falls between zero and 500,000 people.

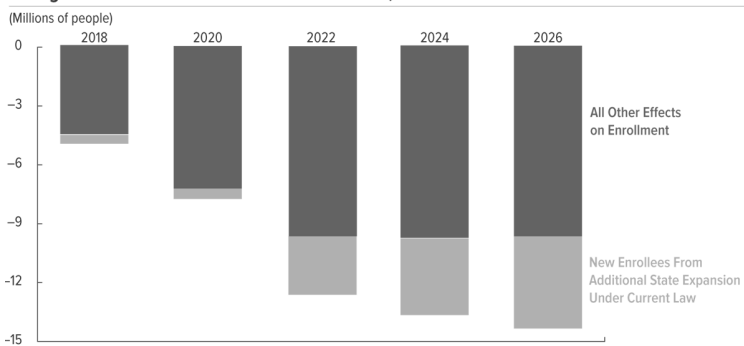
^a Includes noninstitutionalized enrollees with full Medicaid benefits.

^b Under current law, many people can purchase subsidized health insurance coverage through the marketplaces (sometimes called exchanges) operated by the federal government, by state governments, or as partnerships between federal and state governments. People also can purchase unsubsidized coverage in the nongroup market outside of those marketplaces. Under the AHCA, people could receive subsidies for coverage purchased either inside or outside of the marketplaces.

^c Includes coverage under the Basic Health Program, which allows states to establish a coverage program primarily for people whose income is between 138 percent and 200 percent of the federal poverty level. To subsidize that coverage, the federal government provides states with funding that is equal to 95 percent of the subsidies for which those people would otherwise have been eligible by purchasing health insurance through a marketplace. Payments for that program would be rescinded by the AHCA in 2020.

Figure 1.

Changes in Medicaid Enrollment Under the AHCA, Selected Years



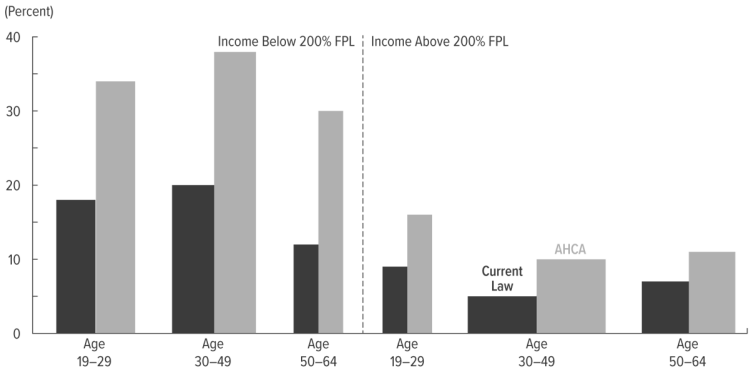
Source: Congressional Budget Office.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. They reflect average enrollment over the course of a year. Under CBO's current-law projections, additional states would expand Medicaid eligibility to people who are made newly eligible under the Affordable Care Act (adults under the age of 65 whose income is below 138 percent of the federal poverty level). Enrollment estimates associated with those future expansions are separated in the figure to highlight the change in Medicaid enrollment under the AHCA because CBO anticipates that states that would expand coverage in the future under current law would not do so under the AHCA.

AHCA = American Health Care Act.

Figure 2.

Share of Nonelderly Adults Without Health Insurance Coverage Under Current Law and Under the AHCA, by Age and Income Level, 2026



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. They reflect the average number of people without insurance coverage over the course of the year in the noninstitutionalized civilian population of the 50 states and the District of Columbia.

The width of each bar represents the relative share of the population in each age and income category. In CBO's projections, 200 percent of the FPL in 2026 would amount to \$30,300 for a single person.

AHCA = American Health Care Act; FPL = federal poverty level.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee advises that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated in the description portions of this report.

B. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the budget reconciliation legislative recommendations contain no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizing funding is required.

C. INFORMATION RELATING TO UNFUNDED MANDATES

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104-4).

The Committee has determined that the budget reconciliation legislative recommendations do not contain any private sector mandates. The Committee has determined that the budget reconciliation legislative recommendations do not impose any Federal inter-governmental mandates on State, local, or tribal governments.

D. APPLICABILITY OF HOUSE RULE XXI 5(b)

Rule XXI 5(b) of the Rules of the House of Representatives provides, in part, that “A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting, a quorum being present.” The Committee has carefully reviewed the provisions of the budget reconciliation legislative recommendations and states that the provisions of the legislative recommendations do not involve any Federal income tax rate increases within the meaning of the rule.

E. TAX COMPLEXITY ANALYSIS

Section 4022(b) of the Internal Revenue Service Restructuring and Reform Act of 1998 (“IRS Reform Act”) requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses.

Pursuant to clause 3(h)(1) of rule XIII of the Rules of the House of Representatives, the staff of the Joint Committee on Taxation has determined that a complexity analysis is not required under section 4022(b) of the IRS Reform Act because the budget reconciliation legislative recommendations contain no provisions that amend the Code and that have “widespread applicability” to individuals or small businesses, within the meaning of the rule.

F. CONGRESSIONAL EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the budget reconciliation legislative recommendations and states that the provisions of the legislative recommendations do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

G. DUPLICATION OF FEDERAL PROGRAMS

In compliance with clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee states that none of the budget reconciliation legislative recommendations establishes or re-authorizes: (1) a program of the Federal Government known to be duplicative of another Federal program, (2) a program included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to section 6104 of title 31, United States Code.

H. DISCLOSURE OF DIRECTED RULE MAKINGS

In compliance with Sec. 3(i) of H. Res. 5 (115th Congress), the following statement is made concerning directed rule makings: The Committee advises that the budget reconciliation legislative recommendations require no directed rule makings within the meaning of such section.

**VI. CHANGES IN EXISTING LAW MADE BY THE BUDGET
RECONCILIATION LEGISLATIVE RECOMMENDATIONS,
AS TRANSMITTED**

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes to existing law made by the recommendations, as transmitted, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in *italic*, and existing law in which no change is proposed is shown in roman):

INTERNAL REVENUE CODE OF 1986

* * * * *

Subtitle A—Income Taxes

* * * * *

CHAPTER 1—NORMAL TAXES AND SURTAXES

* * * * *

Subchapter A—Determination of Tax Liability

* * * * *

PART IV—CREDITS AGAINST TAX

* * * * *

Subpart C—Refundable Credits

Sec. 31. Tax withheld on wages.

* * * * *

Sec. 36C. *Health insurance coverage.*

* * * * *

SEC. 35. HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.

(a) **IN GENERAL.**—In the case of an individual, there shall be allowed as a credit against the tax imposed by subtitle A an amount equal to 72.5 percent of the amount paid by the taxpayer for coverage of the taxpayer and qualifying family members under qualified health insurance for eligible coverage months beginning in the taxable year.

(b) **ELIGIBLE COVERAGE MONTH.**—For purposes of this section—

(1) **IN GENERAL.**—The term “eligible coverage month” means any month if—

(A) as of the first day of such month, the taxpayer—

(i) is an eligible individual,

(ii) is covered by qualified health insurance, the premium for which is paid by the taxpayer,

(iii) does not have other specified coverage, and

(iv) is not imprisoned under Federal, State, or local authority, and

(B) such month begins more than 90 days after the date of the enactment of the Trade Act of 2002, and before January 1, 2020.

(2) JOINT RETURNS.—In the case of a joint return, the requirements of paragraph (1)(A) shall be treated as met with respect to any month if at least 1 spouse satisfies such requirements.

(c) ELIGIBLE INDIVIDUAL.—For purposes of this section—

(1) IN GENERAL.—The term “eligible individual” means—

- (A) an eligible TAA recipient,
- (B) an eligible alternative TAA recipient, and
- (C) an eligible PBGC pension recipient.

(2) ELIGIBLE TAA RECIPIENT.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term “eligible TAA recipient” means, with respect to any month, any individual who is receiving for any day of such month a trade readjustment allowance under chapter 2 of title II of the Trade Act of 1974 or who would be eligible to receive such allowance if section 231 of such Act were applied without regard to subsection (a)(3)(B) of such section. An individual shall continue to be treated as an eligible TAA recipient during the first month that such individual would otherwise cease to be an eligible TAA recipient by reason of the preceding sentence.

(B) SPECIAL RULE.—In the case of any eligible coverage month beginning after the date of the enactment of this paragraph, the term “eligible TAA recipient” means, with respect to any month, any individual who—

(i) is receiving for any day of such month a trade readjustment allowance under chapter 2 of title II of the Trade Act of 1974,

(ii) would be eligible to receive such allowance except that such individual is in a break in training provided under a training program approved under section 236 of such Act that exceeds the period specified in section 233(e) of such Act, but is within the period for receiving such allowances provided under section 233(a) of such Act, or

(iii) is receiving unemployment compensation (as defined in section 85(b)) for any day of such month and who would be eligible to receive such allowance for such month if section 231 of such Act were applied without regard to subsections (a)(3)(B) and (a)(5) thereof.

An individual shall continue to be treated as an eligible TAA recipient during the first month that such individual would otherwise cease to be an eligible TAA recipient by reason of the preceding sentence.

(3) ELIGIBLE ALTERNATIVE TAA RECIPIENT.—The term “eligible alternative TAA recipient” means, with respect to any month, any individual who—

(A) is a worker described in section 246(a)(3)(B) of the Trade Act of 1974 who is participating in the program established under section 246(a)(1) of such Act, and

(B) is receiving a benefit for such month under section 246(a)(2) of such Act.

An individual shall continue to be treated as an eligible alternative TAA recipient during the first month that such individual would otherwise cease to be an eligible alternative TAA recipient by reason of the preceding sentence.

(4) ELIGIBLE PBGC PENSION RECIPIENT.—The term “eligible PBGC pension recipient” means, with respect to any month, any individual who—

(A) has attained age 55 as of the first day of such month, and

(B) is receiving a benefit for such month any portion of which is paid by the Pension Benefit Guaranty Corporation under title IV of the Employee Retirement Income Security Act of 1974.

(d) QUALIFYING FAMILY MEMBER.—For purposes of this section—

(1) IN GENERAL.—The term “qualifying family member” means—

(A) the taxpayer’s spouse, and

(B) any dependent of the taxpayer with respect to whom the taxpayer is entitled to a deduction under section 151(c).

Such term does not include any individual who has other specified coverage.

(2) SPECIAL DEPENDENCY TEST IN CASE OF DIVORCED PARENTS, ETC.—If section 152(e) applies to any child with respect to any calendar year, in the case of any taxable year beginning in such calendar year, such child shall be treated as described in paragraph (1)(B) with respect to the custodial parent (as defined in section 152(e)(4)(A)) and not with respect to the non-custodial parent.

(e) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

(1) IN GENERAL.—The term “qualified health insurance” means any of the following:

(A) Coverage under a COBRA continuation provision (as defined in section 9832(d)(1)).

(B) State-based continuation coverage provided by the State under a State law that requires such coverage.

(C) Coverage offered through a qualified State high risk pool (as defined in section 2744(c)(2) of the Public Health Service Act).

(D) Coverage under a health insurance program offered for State employees.

(E) Coverage under a State-based health insurance program that is comparable to the health insurance program offered for State employees.

(F) Coverage through an arrangement entered into by a State and—

(i) a group health plan (including such a plan which is a multiemployer plan as defined in section 3(37) of the Employee Retirement Income Security Act of 1974),

(ii) an issuer of health insurance coverage,

- (iii) an administrator, or
- (iv) an employer.

(G) Coverage offered through a State arrangement with a private sector health care coverage purchasing pool.

(H) Coverage under a State-operated health plan that does not receive any Federal financial participation.

(I) Coverage under a group health plan that is available through the employment of the eligible individual's spouse.

(J) In the case of any eligible individual and such individual's qualifying family members, coverage under individual health insurance (other than coverage enrolled in through an Exchange established under the Patient Protection and Affordable Care Act). For purposes of this subparagraph, the term "individual health insurance" means any insurance which constitutes medical care offered to individuals other than in connection with a group health plan and does not include Federal- or State-based health insurance coverage.

(K) Coverage under an employee benefit plan funded by a voluntary employees' beneficiary association (as defined in section 501(c)(9)) established pursuant to an order of a bankruptcy court, or by agreement with an authorized representative, as provided in section 1114 of title 11, United States Code.

(2) REQUIREMENTS FOR STATE-BASED COVERAGE.—

(A) IN GENERAL.—The term "qualified health insurance" does not include any coverage described in subparagraphs (B) through (H) of paragraph (1) unless the State involved has elected to have such coverage treated as qualified health insurance under this section and such coverage meets the following requirements:

(i) GUARANTEED ISSUE.—Each qualifying individual is guaranteed enrollment if the individual pays the premium for enrollment or provides a qualified health insurance costs credit eligibility certificate described in section 7527 and pays the remainder of such premium.

(ii) NO IMPOSITION OF PREEXISTING CONDITION EXCLUSION.—No pre-existing condition limitations are imposed with respect to any qualifying individual.

(iii) NONDISCRIMINATORY PREMIUM.—The total premium (as determined without regard to any subsidies) with respect to a qualifying individual may not be greater than the total premium (as so determined) for a similarly situated individual who is not a qualifying individual.

(iv) SAME BENEFITS.—Benefits under the coverage are the same as (or substantially similar to) the benefits provided to similarly situated individuals who are not qualifying individuals.

(B) QUALIFYING INDIVIDUAL.—For purposes of this paragraph, the term "qualifying individual" means—

- (i) an eligible individual for whom, as of the date on which the individual seeks to enroll in the coverage described in subparagraphs (B) through (H) of para-

graph (1), the aggregate of the periods of creditable coverage (as defined in section 9801(c)) is 3 months or longer and who, with respect to any month, meets the requirements of clauses (iii) and (iv) of subsection (b)(1)(A); and

(ii) the qualifying family members of such eligible individual.

(3) EXCEPTION.—The term “qualified health insurance” shall not include—

(A) a flexible spending or similar arrangement, and

(B) any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

(f) OTHER SPECIFIED COVERAGE.—For purposes of this section, an individual has other specified coverage for any month if, as of the first day of such month—

(1) SUBSIDIZED COVERAGE.—

(A) IN GENERAL.—Such individual is covered under any insurance which constitutes medical care (except insurance substantially all of the coverage of which is of excepted benefits described in section 9832(c)) under any health plan maintained by any employer (or former employer) of the taxpayer or the taxpayer’s spouse and at least 50 percent of the cost of such coverage (determined under section 4980B) is paid or incurred by the employer.

(B) ELIGIBLE ALTERNATIVE TAA RECIPIENTS.—In the case of an eligible alternative TAA recipient, such individual is either—

(i) eligible for coverage under any qualified health insurance (other than insurance described in subparagraph (A), (B), or (F) of subsection (e)(1)) under which at least 50 percent of the cost of coverage (determined under section 4980B(f)(4)) is paid or incurred by an employer (or former employer) of the taxpayer or the taxpayer’s spouse, or

(ii) covered under any such qualified health insurance under which any portion of the cost of coverage (as so determined) is paid or incurred by an employer (or former employer) of the taxpayer or the taxpayer’s spouse.

(C) TREATMENT OF CAFETERIA PLANS.—For purposes of subparagraphs (A) and (B), the cost of coverage shall be treated as paid or incurred by an employer to the extent the coverage is in lieu of a right to receive cash or other qualified benefits under a cafeteria plan (as defined in section 125(d)).

(2) COVERAGE UNDER MEDICARE, MEDICAID, OR SCHIP.—Such individual—

(A) is entitled to benefits under part A of title XVIII of the Social Security Act or is enrolled under part B of such title, or

(B) is enrolled in the program under title XIX or XXI of such Act (other than under section 1928 of such Act).

(3) CERTAIN OTHER COVERAGE.—Such individual—

(A) is enrolled in a health benefits plan under chapter 89 of title 5, United States Code, or

(B) is entitled to receive benefits under chapter 55 of title 10, United States Code.

(g) SPECIAL RULES.—

(1) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT.—

With respect to any taxable year, 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 7527 for months beginning in such taxable year.

(2) COORDINATION WITH OTHER DEDUCTIONS.—Amounts taken into account under subsection (a) shall not be taken into account in determining any deduction allowed under section 162(l) or 213.

(3) MEDICAL AND HEALTH SAVINGS ACCOUNTS.—Amounts distributed from an Archer MSA (as defined in section 220(d)) or from a health savings account (as defined in section 223(d)) shall not be taken into account under subsection (a).

(4) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

(5) BOTH SPOUSES ELIGIBLE INDIVIDUALS.—The spouse of the taxpayer shall not be treated as a qualifying family member for purposes of subsection (a), if—

(A) the taxpayer is married at the close of the taxable year,

(B) the taxpayer and the taxpayer's spouse are both eligible individuals during the taxable year, and

(C) the taxpayer files a separate return for the taxable year.

(6) MARITAL STATUS; CERTAIN MARRIED INDIVIDUALS LIVING APART.—Rules similar to the rules of paragraphs (3) and (4) of section 21(e) shall apply for purposes of this section.

(7) 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 qualified health insurance under which amounts are payable for coverage of an individual other than the taxpayer and qualifying family members.

(8) TREATMENT OF PAYMENTS.—For purposes of this section—

(A) PAYMENTS BY SECRETARY.—Payments made by the Secretary on behalf of any individual under section 7527 (relating to advance payment of credit for health insurance costs of eligible individuals) shall be treated as having been made by the taxpayer on the first day of the month for which such payment was made.

(B) PAYMENTS BY TAXPAYER.—Payments made by the taxpayer for eligible coverage months shall be treated as having been made by the taxpayer on the first day of the month for which such payment was made.

(9) **COBRA PREMIUM ASSISTANCE.**—In the case of an assistance eligible individual who receives premium reduction for COBRA continuation coverage under section 3001(a) of title III of division B of the American Recovery and Reinvestment Act of 2009 for any month during the taxable year, such individual shall not be treated as an eligible individual, a certified individual, or a qualifying family member for purposes of this section or section 7527 with respect to such month.

(10) **CONTINUED QUALIFICATION OF FAMILY MEMBERS AFTER CERTAIN EVENTS.**—

(A) **MEDICARE ELIGIBILITY.**—In the case of any month which would be an eligible coverage month with respect to an eligible individual but for subsection (f)(2)(A), such month shall be treated as an eligible coverage month with respect to such eligible individual solely for purposes of determining the amount of the credit under this section with respect to any qualifying family members of such individual (and any advance payment of such credit under section 7527). This subparagraph shall only apply with respect to the first 24 months after such eligible individual is first entitled to the benefits described in subsection (f)(2)(A).

(B) **DIVORCE.**—In the case of the finalization of a divorce between an eligible individual and such individual's spouse, such spouse shall be treated as an eligible individual for purposes of this section and section 7527 for a period of 24 months beginning with the date of such finalization, except that the only qualifying family members who may be taken into account with respect to such spouse are those individuals who were qualifying family members immediately before such finalization.

(C) **DEATH.**—In the case of the death of an eligible individual—

(i) any spouse of such individual (determined at the time of such death) shall be treated as an eligible individual for purposes of this section and section 7527 for a period of 24 months beginning with the date of such death, except that the only qualifying family members who may be taken into account with respect to such spouse are those individuals who were qualifying family members immediately before such death, and

(ii) any individual who was a qualifying family member of the decedent immediately before such death (or, in the case of an individual to whom paragraph (4) applies, the taxpayer to whom the deduction under section 151 is allowable) shall be treated as an eligible individual for purposes of this section and section 7527 for a period of 24 months beginning with the date of such death, except that in determining the amount of such credit only such qualifying family member may be taken into account.

(11) **ELECTION.**—

(A) IN GENERAL.—This section shall not apply to any taxpayer for any eligible coverage month unless such taxpayer elects the application of this section for such month.

(B) TIMING AND APPLICABILITY OF ELECTION.—Except as the Secretary may provide—

(i) an election to have this section apply for any eligible coverage month in a taxable year shall be made not later than the due date (including extensions) for the return of tax for the taxable year; and

(ii) any election for this section to apply for an eligible coverage month shall apply for all subsequent eligible coverage months in the taxable year and, once made, shall be irrevocable with respect to such months.

(12) COORDINATION WITH PREMIUM TAX CREDIT.—

(A) IN GENERAL.—An eligible coverage month to which the election under paragraph (11) applies shall not be treated as a coverage month (as defined in section 36B(c)(2)) for purposes of section 36B with respect to the taxpayer.

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

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

(I) the sum of any advance payments made on behalf of the taxpayer under section 1412 of the Patient Protection and Affordable Care Act and section 7527 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 36B (determined without regard to subsection (f)(1) thereof) for such taxable year; and

(ii) section 36B(f)(2) shall not apply with respect to such taxpayer for such taxable year, except that if such taxpayer received any advance payments under section 7527 for any month in such taxable year and is later allowed a credit under section 36B for such taxable year, then section 36B(f)(2)(B) shall be applied by substituting the amount determined under clause (i) for the amount determined under section 36B(f)(2)(A).

(13) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be necessary or appropriate to carry out this section, section 6050T, and section 7527.

(14) COORDINATION WITH HEALTH INSURANCE COVERAGE CREDIT.—

(A) IN GENERAL.—An eligible coverage month to which the election under paragraph (11) applies shall not be treat-

ed as an eligible coverage month (as defined in section 36C(d)) for purposes of section 36C with respect to the taxpayer or any of the taxpayer's qualifying family members (as defined in section 36C(e)).

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

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

(I) the sum of any advance payments made on behalf of the taxpayer under 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 (i)(5)(A) thereof) for such taxable year, and

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

* * * * *

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

(a) IN GENERAL.—In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.

(b) PREMIUM ASSISTANCE CREDIT AMOUNT.—For purposes of this section—

(1) IN GENERAL.—The term “premium assistance credit amount” means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

(2) PREMIUM ASSISTANCE AMOUNT.—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—

(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer [and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act, or], or

(B) the excess (if any) of—

(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

(3) OTHER TERMS AND RULES RELATING TO PREMIUM ASSISTANCE AMOUNTS.—For purposes of paragraph (2)—

[(A) APPLICABLE PERCENTAGE.—

[(i) IN GENERAL.—Except as provided in clause (ii), 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 premium percentage to the final premium percentage specified in such table for such income tier:

<p> In the case of household income (expressed as a percent of poverty line) within the following income tier: </p>	<p> The initial premium percentage is-- </p>	<p> The final premium percentage is-- </p>
Up to 133%	2.0%	2.0%
133% up to 150%	3.0%	4.0%
150% up to 200%	4.0%	6.3%
200% up to 250%	6.3%	8.05%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%

[(ii) INDEXING.—

[(I) IN GENERAL.—Subject to subclause (II), in the case of taxable years beginning in any calendar year after 2014, the initial and final applicable percentages under clause (i) (as in effect for the preceding calendar year after application of this clause) shall be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year.

[(II) ADDITIONAL ADJUSTMENT.—Except as provided in subclause (III), in the case of any calendar year after 2018, the percentages described in subclause (I) shall, in addition to the adjustment under subclause (I), be adjusted to reflect the excess (if any) of the rate of premium growth estimated under subclause (I) for the preceding calendar year over the rate of growth in the consumer price index for the preceding calendar year.

[(III) FAILSAFE.—Subclause (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.]

(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 fol-

lowing 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:

<i>In the case of household income come (expressed as a percent of the poverty line) within the following income tier:</i>	<i>Up to Age 29</i>	<i>Age 30- 39</i>	<i>Age 40- 49</i>	<i>Age 50- 59</i>	<i>Over Age 59</i>					
					<i>Initial %</i>	<i>Final %</i>	<i>Initial %</i>	<i>Final %</i>	<i>Initial %</i>	<i>Final %</i>
<i>Up to 133%</i>	2	2	2	2	2	2	2	2	2	2
<i>133%-150%</i>	3	4	3	4	3	4	3	4	3	4
<i>150%-200%</i>	4	4.3	4	5.3	4	6.3	4	7.3	4	8.3
<i>200%-250%</i>	4.3	4.3	5.3	5.9	6.3	8.05	7.3	9	8.3	10
<i>250%-300%</i>	4.3	4.3	5.9	5.9	8.05	8.35	9	10.5	10	11.5
<i>300%-400%</i>	4.3	4.3	5.9	5.9	8.35	8.35	10.5	10.5	11.5	11.5

(ii) *AGE DETERMINATIONS.*—

(I) *IN GENERAL.*—For purposes of clause (i), the age of the taxpayer taken into account under clause (i) with respect to any taxable year is the age attained by such taxpayer before the close of such taxable year.

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

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

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

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

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

(B) *APPLICABLE SECOND LOWEST COST SILVER PLAN.*—The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—

(i) is offered through [the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and] *the Exchange through which such taxpayer is permitted to obtain coverage, and*

(ii) provides—

(I) self-only coverage in the case of an applicable taxpayer—

(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

(bb) who is not described in item (aa) but who purchases only self-only coverage, and

(II) family coverage in the case of any other applicable taxpayer.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by rea-

son of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than either spouse and subsection (e) does not apply to the dependent.

(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

(D) ADDITIONAL BENEFITS.—If—

(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits required to be provided by the plan, or

(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,

the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

(E) SPECIAL RULE FOR PEDIATRIC DENTAL COVERAGE.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii) (I) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

(c) DEFINITION AND RULES RELATING TO APPLICABLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED HEALTH PLAN.—For purposes of this section—

(1) APPLICABLE TAXPAYER.—

(A) IN GENERAL.—The term “applicable taxpayer” means, with respect to any taxable year, a taxpayer whose household income for the taxable year equals or exceeds 100 per-

cent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

(B) SPECIAL RULE FOR CERTAIN INDIVIDUALS LAWFULLY PRESENT IN THE UNITED STATES.—If—

(i) a taxpayer has a household income which is not greater than 100 percent of an amount equal to the poverty line for a family of the size involved, and

(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the medicaid program under title XIX of the Social Security Act by reason of such alien status,

the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

(C) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

(D) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

(2) COVERAGE MONTH.—For purposes of this subsection—

(A) IN GENERAL.—The term “coverage month” means, with respect to an applicable taxpayer, any month if—

(i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and

(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).

(B) EXCEPTION FOR MINIMUM ESSENTIAL COVERAGE.—

(i) IN GENERAL.—The term “coverage month” shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

(ii) MINIMUM ESSENTIAL COVERAGE.—The term “minimum essential coverage” has the meaning given such term by section 5000A(f).

(C) SPECIAL RULE FOR EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.—For purposes of subparagraph (B)—

(i) **COVERAGE MUST BE AFFORDABLE.**—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage—

(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

(II) the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the applicable taxpayer's household income.

This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

(ii) **COVERAGE MUST PROVIDE MINIMUM VALUE.**—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

(iii) **EMPLOYEE OR FAMILY MUST NOT BE COVERED UNDER EMPLOYER PLAN.**—Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

(iv) **INDEXING.**—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

(3) **DEFINITIONS AND OTHER RULES.**—

(A) **QUALIFIED HEALTH PLAN.**—The term “qualified health plan” has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act (*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*), except that such term **shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.** *shall not include any health plan that—*

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

(ii) includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).

(B) **GRANDFATHERED HEALTH PLAN.**—The term “grandfathered health plan” has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

(C) **GRANDMOTHERED HEALTH PLAN.**—

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

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

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

(D) CERTAIN RULES RELATED TO ABORTION.—

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

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

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

(A) *IN GENERAL.*—The term “coverage month” shall not include any month with respect to an employee (or any spouse or dependent of such employee) if for such month the employee is provided a qualified small employer health

reimbursement arrangement which constitutes affordable coverage.

(B) DENIAL OF DOUBLE BENEFIT.—In the case of any employee who is provided a qualified small employer health reimbursement arrangement for any coverage month (determined without regard to subparagraph (A)), the credit otherwise allowable under subsection (a) to the taxpayer for such month shall be reduced (but not below zero) by the amount described in subparagraph (C)(i)(II) for such month.

(C) AFFORDABLE COVERAGE.—For purposes of subparagraph (A), a qualified small employer health reimbursement arrangement shall be treated as constituting affordable coverage for a month if—

(i) the excess of—

(I) the amount that would be paid by the employee as the premium for such month for self-only coverage under the second lowest cost silver plan offered in the relevant individual health insurance market, over

(II) $\frac{1}{12}$ of the employee's permitted benefit (as defined in section 9831(d)(3)(C)) under such arrangement, does not exceed—

(ii) $\frac{1}{12}$ of 9.5 percent of the employee's household income.

(D) 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).

(E) 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 (C)(i)(II) shall be applied by substituting “the number of months during the year for which such arrangement was provided” for “12”.

(F) INDEXING.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent amount under subparagraph (C)(ii) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

(d) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

(1) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(2) HOUSEHOLD INCOME.—

(A) HOUSEHOLD INCOME.—The term “household income” means, with respect to any taxpayer, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(B) MODIFIED ADJUSTED GROSS INCOME.—The term “modified adjusted gross income” means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911,

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax, and

(iii) an amount equal to the portion of the taxpayer's social security benefits (as defined in section 86(d)) which is not included in gross income under section 86 for the taxable year.

(3) POVERTY LINE.—

(A) IN GENERAL.—The term “poverty line” has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

(B) POVERTY LINE USED.—In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

(1) IN GENERAL.—If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present—

(A) the aggregate amount of premiums otherwise taken into account under clauses (i) and (ii) of subsection (b)(2)(A) shall be reduced by the portion (if any) of such premiums which is attributable to such individuals, and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which—

(I) the taxpayer's family size is determined by not taking such individuals into account, and

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) **LAWFULLY PRESENT.**—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the credit under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) **SECRETARIAL AUTHORITY.**—The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) **RECONCILIATION OF CREDIT AND ADVANCE CREDIT.**—

(1) **IN GENERAL.**—The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit under section 1412 of the Patient Protection and Affordable Care Act.

(2) **EXCESS ADVANCE PAYMENTS.**—

(A) **IN GENERAL.**—If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

(B) **LIMITATION ON INCREASE.**—

(i) **IN GENERAL.**—In the case of a taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed the applicable dollar amount determined in accordance with the following table (one-half of such amount in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year):

If the household income (expressed as a percent of poverty line) is:	The applicable dollar amount is:
Less than 200%	\$600
At least 200% but less than 300%	\$1,500
At least 300% but less than 400%	\$2,500

(ii) **INDEXING OF AMOUNT.**—In the case of any calendar year beginning after 2014, each of the dollar amounts in the table contained under clause (i) 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, determined by substituting “calendar year 2013” for “calendar year 1992” in subparagraph (B) thereof.
 If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

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

(3) **INFORMATION REQUIREMENT.**—Each Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) or 1321(c) of the Patient Protection and Affordable Care Act) shall provide the following information to the Secretary and to the taxpayer with respect to any health plan provided through the Exchange:

(A) The level of coverage described in section 1302(d) of the Patient Protection and Affordable Care Act and the period such coverage was in effect.

(B) The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of such Act.

(C) The aggregate amount of any advance payment of such credit or reductions under section 1412 of such Act.

(D) The name, address, and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy.

(E) Any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit.

(F) Information necessary to determine whether a taxpayer has received excess advance payments.

(g) **REGULATIONS.**—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for—

(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and

(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.

(h) **TERMINATION.**—*No credit shall be allowed under this section with respect to any coverage month which begins after December 31, 2019.*

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 sum of the monthly credit amounts with respect to such taxpayer for calendar months during such taxable year.*

(b) **MONTHLY CREDIT AMOUNTS.**—

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

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

(B) the amount paid for eligible health insurance for the taxpayer and the taxpayer's qualifying family members for such month.

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

(c) *MONTHLY LIMITATION AMOUNTS.*—

(1) *IN GENERAL.*—The monthly limitation amount with respect to any individual for any eligible coverage month during any taxable year is $\frac{1}{12}$ of—

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

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

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

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

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

(2) *LIMITATION BASED ON MODIFIED ADJUSTED GROSS INCOME.*—

(A) *IN GENERAL.*—The amount otherwise determined under subsection (b)(1)(A) (without regard to this subparagraph but after any other adjustment of such amount under this section) for the taxable year shall be reduced (but not below zero) by 10 percent of the excess (if any) of—

(i) the taxpayer's modified adjusted gross income for such taxable year, over

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

(B) *MODIFIED ADJUSTED GROSS INCOME.*—For purposes of this paragraph, the term “modified adjusted gross income” means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911,

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax, and

(iii) an amount equal to the portion of the taxpayer's social security benefits (as defined in section 86(d)) which is not included in gross income under section 86 for the taxable year.

(3) *OTHER LIMITATIONS.*—

(A) *AGGREGATE DOLLAR LIMITATION.*—The sum of the monthly limitation amounts taken into account under this

section with respect to any taxpayer for any taxable year shall not exceed \$14,000.

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

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

- (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.

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

- (1) in the case of a joint return, the taxpayer’s spouse,
- (2) any dependent of the taxpayer, and

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

(f) **ELIGIBLE HEALTH INSURANCE.**—For purposes of this section—

(1) **IN GENERAL** The term “eligible health insurance” means any health insurance coverage (as defined in section 9832(b)) if—

(A) such coverage is either—

(i) offered in the individual health insurance market within a State, or

(ii) is unsubsidized COBRA continuation coverage,

(B) such coverage is not a grandfathered health plan (as defined in section 1251 of the Patient Protection and Affordable Care Act) or a grandmothers health plan,

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

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

(E) such coverage does not consist of short-term limited duration insurance (as defined by the Secretary), and

(F) the State in which such insurance is offered certifies that such coverage meets the requirements of this paragraph.

(2) **RULES RELATED TO STATE CERTIFICATION.**—

(A) *CERTIFICATION MADE AVAILABLE TO PUBLIC.*—A certification shall not be taken into account under paragraph (1)(E) unless such certification is made available to the public and meets such other requirements as the Secretary may provide.

(B) *SPECIAL RULE FOR UNSUBSIDIZED COBRA CONTINUATION COVERAGE.*—In the case of unsubsidized COBRA continuation coverage—

(i) paragraph (1)(E) shall be applied by substituting “the plan administrator (as defined in section 414(g)) of the health plan” for “the State in which such insurance is offered”, and

(ii) the requirements of subparagraph (A) shall be treated as satisfied if the certification meets such requirements as the Secretary may provide.

(3) *GRANDMOTHERED HEALTH PLAN.*—

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

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

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

(g) *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—

(i) coverage under a plan substantially all of the coverage of which is of excepted benefits described in section 9832(c), and

(ii) COBRA continuation coverage.

(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).

(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.

(h) UNSUBSIDIZED COBRA CONTINUATION COVERAGE.—For purposes of this section—

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

(2) 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.

(i) 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.—

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

(B) COORDINATION WITH RULE FOR OLDER CHILDREN.—In the case of any individual who is a qualifying family member described in subsection (e)(3) with respect to another taxpayer for any month, in determining the amount of any credit allowable to such individual under this section for any taxable year of such individual which includes such

month, the monthly limitation amount with respect to such individual for such month shall be zero and no amount paid for eligible health insurance with respect to such individual for such month shall be taken into account.

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

(4) **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 sum determined under subsection (b)(1)(A) with respect to the taxpayer for such month shall be reduced (but not below zero) by $\frac{1}{12}$ 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) **CERTAIN RULES RELATED TO ABORTION.**—

(A) *OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.*—Nothing in subsection (f)(1)(D) 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 (f)(1)(D) shall restrict any 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.

(C) *OTHER TREATMENTS.*—The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion shall not be treated as an abortion for purposes of subsection (f)(1)(D).

(8) *INFLATION ADJUSTMENT.*—

(A) *IN GENERAL.*—In the case of any taxable year beginning in a calendar year after 2020, each dollar amount in subsection (c)(1), the \$75,000 amount in subsection (c)(2)(A)(ii), and the dollar amount in subsection (c)(3)(A), shall be increased by an amount equal to—

(i) such dollar amount, multiplied by

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

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

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

(B) *TERMS RELATED TO CPI.*—

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

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

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

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

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Subpart D—Business Related Credits

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SEC. 45R. EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.

(a) **GENERAL RULE.**—For purposes of section 38, in the case of an eligible small employer, the small employer health insurance credit determined under this section for any taxable year in the credit period is the amount determined under subsection (b).

(b) **HEALTH INSURANCE CREDIT AMOUNT.**—Subject to subsection (c), the amount determined under this subsection with respect to any eligible small employer is equal to 50 percent (35 percent in the case of a tax-exempt eligible small employer) of the lesser of—

(1) the aggregate amount of nonelective contributions the employer made on behalf of its employees during the taxable year under the arrangement described in subsection (d)(4) for premiums for qualified health plans offered by the employer to its employees through an Exchange, or

(2) the aggregate amount of nonelective contributions which the employer would have made during the taxable year under the arrangement if each employee taken into account under paragraph (1) had enrolled in a qualified health plan which had a premium equal to the average premium (as determined by the Secretary of Health and Human Services) for the small group market in the rating area in which the employee enrolls for coverage.

(c) **PHASEOUT OF CREDIT AMOUNT BASED ON NUMBER OF EMPLOYEES AND AVERAGE WAGES.**—The amount of the credit determined under subsection (b) without regard to this subsection shall be reduced (but not below zero) by the sum of the following amounts:

(1) Such amount multiplied by a fraction the numerator of which is the total number of full-time equivalent employees of the employer in excess of 10 and the denominator of which is 15.

(2) Such amount multiplied by a fraction the numerator of which is the average annual wages of the employer in excess of the dollar amount in effect under subsection (d)(3)(B) and the denominator of which is such dollar amount.

(d) **ELIGIBLE SMALL EMPLOYER.**—For purposes of this section—

(1) **IN GENERAL.**—The term “eligible small employer” means, with respect to any taxable year, an employer—

(A) which has no more than 25 full-time equivalent employees for the taxable year,

(B) the average annual wages of which do not exceed an amount equal to twice the dollar amount in effect under paragraph (3)(B) for the taxable year, and

(C) which has in effect an arrangement described in paragraph (4).

(2) **FULL-TIME EQUIVALENT EMPLOYEES.**—

(A) **IN GENERAL.**—The term “full-time equivalent employees” means a number of employees equal to the number determined by dividing—

(i) the total number of hours of service for which wages were paid by the employer to employees during the taxable year, by

(ii) 2,080.

Such number shall be rounded to the next lowest whole number if not otherwise a whole number.

(B) EXCESS HOURS NOT COUNTED.—If an employee works in excess of 2,080 hours of service during any taxable year, such excess shall not be taken into account under subparagraph (A).

(C) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

(3) AVERAGE ANNUAL WAGES.—

(A) IN GENERAL.—The average annual wages of an eligible small employer for any taxable year is the amount determined by dividing—

(i) the aggregate amount of wages which were paid by the employer to employees during the taxable year, by

(ii) the number of full-time equivalent employees of the employee determined under paragraph (2) for the taxable year.

Such amount shall be rounded to the next lowest multiple of \$1,000 if not otherwise such a multiple.

(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B) and subsection (c)(2)—

(i) 2010, 2011, 2012, AND 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2010, 2011, 2012, or 2013 is \$25,000.

(ii) SUBSEQUENT YEARS.—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to \$25,000, multiplied by the cost-of-living adjustment under section 1(f)(3) for the calendar year, determined by substituting “calendar year 2012” for “calendar year 1992” in subparagraph (B) thereof.

(4) CONTRIBUTION ARRANGEMENT.—An arrangement is described in this paragraph if it requires an eligible small employer to make a nonelective contribution on behalf of each employee who enrolls in a qualified health plan offered to employees by the employer through an exchange in an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of the qualified health plan.

(5) SEASONAL WORKER HOURS AND WAGES NOT COUNTED.—For purposes of this subsection—

(A) IN GENERAL.—The number of hours of service worked by, and wages paid to, a seasonal worker of an employer shall not be taken into account in determining the full-time equivalent employees and average annual wages of the employer unless the worker works for the employer on more than 120 days during the taxable year.

(B) DEFINITION OF SEASONAL WORKER.—The term “seasonal worker” means a worker who performs labor or services on a seasonal basis as defined by the Secretary of

Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

(e) OTHER RULES AND DEFINITIONS.—For purposes of this section—

(1) EMPLOYEE.—

(A) CERTAIN EMPLOYEES EXCLUDED.—The term “employee” shall not include—

(i) an employee within the meaning of section 401(c)(1),

(ii) any 2-percent shareholder (as defined in section 1372(b)) of an eligible small business which is an S corporation,

(iii) any 5-percent owner (as defined in section 416(i)(1)(B)(i)) of an eligible small business, or

(iv) any individual who bears any of the relationships described in subparagraphs (A) through (G) of section 152(d)(2) to, or is a dependent described in section 152(d)(2)(H) of, an individual described in clause (i), (ii), or (iii).

(B) LEASED EMPLOYEES.—The term “employee” shall include a leased employee within the meaning of section 414(n).

(2) CREDIT PERIOD.—The term “credit period” means, with respect to any eligible small employer, the 2-consecutive-taxable year period beginning with the 1st taxable year in which the employer (or any predecessor) offers 1 or more qualified health plans to its employees through an Exchange.

(3) NONELECTIVE CONTRIBUTION.—The term “nonelective contribution” means an employer contribution other than an employer contribution pursuant to a salary reduction arrangement.

(4) WAGES.—The term “wages” has the meaning given such term by section 3121(a) (determined without regard to any dollar limitation contained in such section).

(5) AGGREGATION AND OTHER RULES MADE APPLICABLE.—

(A) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer for purposes of this section.

(B) OTHER RULES.—Rules similar to the rules of subsections (c), (d), and (e) of section 52 shall apply.

(f) CREDIT MADE AVAILABLE TO TAX-EXEMPT ELIGIBLE SMALL EMPLOYERS.—

(1) IN GENERAL.—In the case of a tax-exempt eligible small employer, there shall be treated as a credit allowable under subpart C (and not allowable under this subpart) the lesser of—

(A) the amount of the credit determined under this section with respect to such employer, or

(B) the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins.

(2) TAX-EXEMPT ELIGIBLE SMALL EMPLOYER.—For purposes of this section, the term “tax-exempt eligible small employer”

means an eligible small employer which is any organization described in section 501(c) which is exempt from taxation under section 501(a).

(3) PAYROLL TAXES.—For purposes of this subsection—

(A) IN GENERAL.—The term “payroll taxes” means—

(i) amounts required to be withheld from the employees of the tax-exempt eligible small employer under section 3401(a),

(ii) amounts required to be withheld from such employees under section 3101(b), and

(iii) amounts of the taxes imposed on the tax-exempt eligible small employer under section 3111(b).

(B) SPECIAL RULE.—A rule similar to the rule of section 24(d)(2)(C) shall apply for purposes of subparagraph (A).

(g) APPLICATION OF SECTION FOR CALENDAR YEARS 2010, 2011, 2012, AND 2013.—In the case of any taxable year beginning in 2010, 2011, 2012, or 2013, the following modifications to this section shall apply in determining the amount of the credit under subsection (a):

(1) NO CREDIT PERIOD REQUIRED.—The credit shall be determined without regard to whether the taxable year is in a credit period and for purposes of applying this section to taxable years beginning after 2013, no credit period shall be treated as beginning with a taxable year beginning before 2014.

(2) AMOUNT OF CREDIT.—The amount of the credit determined under subsection (b) shall be determined—

(A) by substituting “35 percent (25 percent in the case of a tax-exempt eligible small employer)” for “50 percent (35 percent in the case of a tax-exempt eligible small employer)”,

(B) by reference to an eligible small employer’s nonelective contributions for premiums paid for health insurance coverage (within the meaning of section 9832(b)(1)) of an employee, and

(C) by substituting for the average premium determined under subsection (b)(2) the amount the Secretary of Health and Human Services determines is the average premium for the small group market in the State in which the employer is offering health insurance coverage (or for such area within the State as is specified by the Secretary).

(3) CONTRIBUTION ARRANGEMENT.—An arrangement shall not fail to meet the requirements of subsection (d)(4) solely because it provides for the offering of insurance outside of an Exchange.

(h) INSURANCE DEFINITIONS.—**[Any term]**

(1) *IN GENERAL.*—*Any term* used in this section which is also used in the Public Health Service Act or subtitle A of title I of the Patient Protection and Affordable Care Act shall have the meaning given such term by such Act or subtitle.

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

(A) *IN GENERAL.*—*The term “qualified health plan” does not include any health plan that includes coverage for abortions (other than any abortion necessary to save the life*

of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).

(B) CERTAIN RULES RELATED TO ABORTION.—

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

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

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

(i) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations to prevent the avoidance of the 2-year limit on the credit period through the use of successor entities and the avoidance of the limitations under subsection (c) through the use of multiple entities.

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

* * * * *

Subchapter B—Computation of Taxable Income

* * * * *

PART III—ITEMS SPECIFICALLY EXCLUDED FROM GROSS INCOME

* * * * *

SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.

(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

(b) CONTRIBUTIONS TO ARCHER MSAS.—

(1) IN GENERAL.—In the case of an employee who is an eligible individual, amounts contributed by such employee's employer to any Archer MSA of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not ex-

ceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

(2) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

(3) SPECIAL RULE FOR DEDUCTION OF EMPLOYER CONTRIBUTIONS.—Any employer contribution to an Archer MSA, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

(4) EMPLOYER MSA CONTRIBUTIONS REQUIRED TO BE SHOWN ON RETURN.—Every individual required to file a return under section 6012 for the taxable year shall include on such return the aggregate amount contributed by employers to the Archer MSAs of such individual or such individual's spouse for such taxable year.

(5) MSA CONTRIBUTIONS NOT PART OF COBRA COVERAGE.—Paragraph (1) shall not apply for purposes of section 4980B.

(6) DEFINITIONS.—For purposes of this subsection, the terms “eligible individual” and “Archer MSA” have the respective meanings given to such terms by section 220.

(7) CROSS REFERENCE.—For penalty on failure by employer to make comparable contributions to the Archer MSAs of comparable employees, see section 4980E.

(c) INCLUSION OF LONG-TERM CARE BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

(1) IN GENERAL.—Gross income of an employee shall include employer-provided coverage for qualified long-term care services (as defined in section 7702B(c)) to the extent that such coverage is provided through a flexible spending or similar arrangement.

(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.

(d) CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.—

(1) IN GENERAL.—In the case of an employee who is an eligible individual (as defined in section 223(c)(1)), amounts contributed by such employee's employer to any health savings account (as defined in section 223(d)) of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 223(b) (determined

without regard to this subsection) which is applicable to such employee for such taxable year.

(2) SPECIAL RULES.—Rules similar to the rules of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply for purposes of this subsection.

(3) CROSS REFERENCE.—For penalty on failure by employer to make comparable contributions to the health savings accounts of comparable employees, see section 4980G.

(e) FSA AND HRA TERMINATIONS TO FUND HSAS.—

(1) IN GENERAL.—A plan shall not fail to be treated as a health flexible spending arrangement or health reimbursement arrangement under this section or section 105 merely because such plan provides for a qualified HSA distribution.

(2) QUALIFIED HSA DISTRIBUTION.—The term “qualified HSA distribution” means a distribution from a health flexible spending arrangement or health reimbursement arrangement to the extent that such distribution—

(A) does not exceed the lesser of the balance in such arrangement on September 21, 2006, or as of the date of such distribution, and

(B) is contributed by the employer directly to the health savings account of the employee before January 1, 2012.

Such term shall not include more than 1 distribution with respect to any arrangement.

(3) ADDITIONAL TAX FOR FAILURE TO MAINTAIN HIGH DEDUCTIBLE HEALTH PLAN COVERAGE.—

(A) IN GENERAL.—If, at any time during the testing period, the employee is not an eligible individual, then the amount of the qualified HSA distribution—

(i) shall be includible in the gross income of the employee for the taxable year in which occurs the first month in the testing period for which such employee is not an eligible individual, and

(ii) the tax imposed by this chapter for such taxable year on the employee shall be increased by 10 percent of the amount which is so includible.

(B) EXCEPTION FOR DISABILITY OR DEATH.—Clauses (i) and (ii) of subparagraph (A) shall not apply if the employee ceases to be an eligible individual by reason of the death of the employee or the employee becoming disabled (within the meaning of section 72(m)(7)).

(4) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

(A) TESTING PERIOD.—The term “testing period” means the period beginning with the month in which the qualified HSA distribution is contributed to the health savings account and ending on the last day of the 12th month following such month.

(B) ELIGIBLE INDIVIDUAL.—The term “eligible individual” has the meaning given such term by section 223(c)(1).

(C) TREATMENT AS ROLLOVER CONTRIBUTION.—A qualified HSA distribution shall be treated as a rollover contribution described in section 223(f)(5).

(5) TAX TREATMENT RELATING TO DISTRIBUTIONS.—For purposes of this title—

(A) IN GENERAL.—A qualified HSA distribution shall be treated as a payment described in subsection (d).

(B) COMPARABILITY EXCISE TAX.—

(i) IN GENERAL.—Except as provided in clause (ii), section 4980G shall not apply to qualified HSA distributions.

(ii) FAILURE TO OFFER TO ALL EMPLOYEES.—In the case of a qualified HSA distribution to any employee, the failure to offer such distribution to any eligible individual covered under a high deductible health plan of the employer shall (notwithstanding section 4980G(d)) be treated for purposes of section 4980G as a failure to meet the requirements of section 4980G(b).

[(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.]

[(g)] (f) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this section and section 105, payments or reimbursements from a qualified small employer health reimbursement arrangement (as defined in section 9831(d)) of an individual for medical care (as defined in section 213(d)) shall not be treated as paid or reimbursed under employer-provided coverage for medical expenses under an accident or health plan if for the month in which such medical care is provided the individual does not have minimum essential coverage (within the meaning of section 5000A(f)).

* * * * *

SEC. 125. CAFETERIA PLANS.

(a) GENERAL RULE.—Except as provided in subsection (b), no amount shall be included in the gross income of a participant in a cafeteria plan solely because, under the plan, the participant may choose among the benefits of the plan.

(b) EXCEPTION FOR HIGHLY COMPENSATED PARTICIPANTS AND KEY EMPLOYEES.—

(1) HIGHLY COMPENSATED PARTICIPANTS.—In the case of a highly compensated participant, subsection (a) shall not apply to any benefit attributable to a plan year for which the plan discriminates in favor of—

(A) highly compensated individuals as to eligibility to participate, or

(B) highly compensated participants as to contributions and benefits.

(2) KEY EMPLOYEES.—In the case of a key employee (within the meaning of section 416(i)(1)), subsection (a) shall not apply to any benefit attributable to a plan for which the qualified benefits provided to key employees exceed 25 percent of the aggregate of such benefits provided for all employees under the

plan. For purposes of the preceding sentence, qualified benefits shall be determined without regard to the second sentence of subsection (f).

(3) YEAR OF INCLUSION.—For purposes of determining the taxable year of inclusion, any benefit described in paragraph (1) or (2) shall be treated as received or accrued in the taxable year of the participant or key employee in which the plan year ends.

(c) DISCRIMINATION AS TO BENEFITS OR CONTRIBUTIONS.—For purposes of subparagraph (B) of subsection (b)(1), a cafeteria plan does not discriminate where qualified benefits and total benefits (or employer contributions allocable to qualified benefits and employer contributions for total benefits) do not discriminate in favor of highly compensated participants.

(d) CAFETERIA PLAN DEFINED.—For purposes of this section—

(1) IN GENERAL.—The term “cafeteria plan” means a written plan under which—

(A) all participants are employees, and

(B) the participants may choose among 2 or more benefits consisting of cash and qualified benefits.

(2) DEFERRED COMPENSATION PLANS EXCLUDED.—

(A) IN GENERAL.—The term “cafeteria plan” does not include any plan which provides for deferred compensation.

(B) EXCEPTION FOR CASH AND DEFERRED ARRANGEMENTS.—Subparagraph (A) shall not apply to a profit-sharing or stock bonus plan or rural cooperative plan (within the meaning of section 401(k)(7)) which includes a qualified cash or deferred arrangement (as defined in section 401(k)(2)) to the extent of amounts which a covered employee may elect to have the employer pay as contributions to a trust under such plan on behalf of the employee.

(C) EXCEPTION FOR CERTAIN PLANS MAINTAINED BY EDUCATIONAL INSTITUTIONS.—Subparagraph (A) shall not apply to a plan maintained by an educational organization described in section 170(b)(1)(A)(ii) to the extent of amounts which a covered employee may elect to have the employer pay as contributions for post-retirement group life insurance if—

(i) all contributions for such insurance must be made before retirement, and

(ii) such life insurance does not have a cash surrender value at any time.

For purposes of section 79, any life insurance described in the preceding sentence shall be treated as group-term life insurance.

(D) EXCEPTION FOR HEALTH SAVINGS ACCOUNTS.—Subparagraph (A) shall not apply to a plan to the extent of amounts which a covered employee may elect to have the employer pay as contributions to a health savings account established on behalf of the employee.

(e) HIGHLY COMPENSATED PARTICIPANT AND INDIVIDUAL DEFINED.—For purposes of this section—

(1) HIGHLY COMPENSATED PARTICIPANT.—The term “highly compensated participant” means a participant who is—

- (A) an officer,
- (B) a shareholder owning more than 5 percent of the voting power or value of all classes of stock of the employer,
- (C) highly compensated, or
- (D) a spouse or dependent (within the meaning of section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of an individual described in subparagraph (A), (B), or (C).

(2) HIGHLY COMPENSATED INDIVIDUAL.—The term “highly compensated individual” means an individual who is described in subparagraphs (A), (B), (C), or (D) of paragraph (1).

(f) QUALIFIED BENEFITS DEFINED.—For purposes of this section—

(1) IN GENERAL.—The term “qualified benefit” means any benefit which, with the application of subsection (a), is not includible in the gross income of the employee by reason of an express provision of this chapter (other than section 106(b), 117, 127, or 132). Such term includes any group term life insurance which is includible in gross income only because it exceeds the dollar limitation of section 79 and such term includes any other benefit permitted under regulations.

(2) LONG-TERM CARE INSURANCE NOT QUALIFIED.—The term “qualified benefit” shall not include any product which is advertised, marketed, or offered as long-term care insurance.

(3) CERTAIN EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS NOT QUALIFIED.—

(A) IN GENERAL.—The term “qualified benefit” shall not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an Exchange established under section 1311 of such Act.

(B) EXCEPTION FOR EXCHANGE-ELIGIBLE EMPLOYERS.—Subparagraph (A) shall not apply with respect to any employee if such employee’s employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the employee the opportunity to enroll through such an Exchange in a qualified health plan in a group market.

(g) SPECIAL RULES.—

(1) COLLECTIVELY BARGAINED PLAN NOT CONSIDERED DISCRIMINATORY.—For purposes of this section, a plan shall not be treated as discriminatory if the plan is maintained under an agreement which the Secretary finds to be a collective bargaining agreement between employee representatives and one or more employers.

(2) HEALTH BENEFITS.—For purposes of subparagraph (B) of subsection (b)(1), a cafeteria plan which provides health benefits shall not be treated as discriminatory if—

(A) contributions under the plan on behalf of each participant include an amount which—

- (i) equals 100 percent of the cost of the health benefit coverage under the plan of the majority of the highly compensated participants similarly situated, or
- (ii) equals or exceeds 75 percent of the cost of the health benefit coverage of the participant (similarly

situated) having the highest cost health benefit coverage under the plan, and

(B) contributions or benefits under the plan in excess of those described in subparagraph (A) bear a uniform relationship to compensation.

(3) CERTAIN PARTICIPATION ELIGIBILITY RULES NOT TREATED AS DISCRIMINATORY.—For purposes of subparagraph (A) of subsection (b)(1), a classification shall not be treated as discriminatory if the plan—

(A) benefits a group of employees described in section 410(b)(2)(A)(i), and

(B) meets the requirements of clauses (i) and (ii):

(i) No employee is required to complete more than 3 years of employment with the employer or employers maintaining the plan as a condition of participation in the plan, and the employment requirement for each employee is the same.

(ii) Any employee who has satisfied the employment requirement of clause (i) and who is otherwise entitled to participate in the plan commences participation no later than the first day of the first plan year beginning after the date the employment requirement was satisfied unless the employee was separated from service before the first day of that plan year.

(4) CERTAIN CONTROLLED GROUPS, ETC.—All employees who are treated as employed by a single employer under subsection (b), (c), or (m) of section 414 shall be treated as employed by a single employer for purposes of this section.

(h) SPECIAL RULE FOR UNUSED BENEFITS IN HEALTH FLEXIBLE SPENDING ARRANGEMENTS OF INDIVIDUALS CALLED TO ACTIVE DUTY.—

(1) IN GENERAL.—For purposes of this title, a plan or other arrangement shall not fail to be treated as a cafeteria plan or health flexible spending arrangement (and shall not fail to be treated as an accident or health plan) merely because such arrangement provides for qualified reservist distributions.

(2) QUALIFIED RESERVIST DISTRIBUTION.—For purposes of this subsection, the term “qualified reservist distribution” means any distribution to an individual of all or a portion of the balance in the employee’s account under such arrangement if—

(A) such individual was (by reason of being a member of a reserve component (as defined in section 101 of title 37, United States Code)) ordered or called to active duty for a period in excess of 179 days or for an indefinite period, and

(B) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under such arrangement for the plan year which includes the date of such order or call.

[(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

[(1) IN GENERAL.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit

shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of \$2,500 made to such arrangement.

[(2) ADJUSTMENT FOR INFLATION.—In the case of any taxable year beginning after December 31, 2013, the dollar amount in paragraph (1) shall be increased by an amount equal to—

[(A) such amount, multiplied by

[(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting “calendar year 2012” for “calendar year 1992” in subparagraph (B) thereof.

If any increase determined under this paragraph is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.]

(j) SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.—

(1) IN GENERAL.—An eligible employer maintaining a simple cafeteria plan with respect to which the requirements of this subsection are met for any year shall be treated as meeting any applicable nondiscrimination requirement during such year.

(2) SIMPLE CAFETERIA PLAN.—For purposes of this subsection, the term “simple cafeteria plan” means a cafeteria plan—

(A) which is established and maintained by an eligible employer, and

(B) with respect to which the contribution requirements of paragraph (3), and the eligibility and participation requirements of paragraph (4), are met.

(3) CONTRIBUTION REQUIREMENTS.—

(A) IN GENERAL.—The requirements of this paragraph are met if, under the plan the employer is required, without regard to whether a qualified employee makes any salary reduction contribution, to make a contribution to provide qualified benefits under the plan on behalf of each qualified employee in an amount equal to—

(i) a uniform percentage (not less than 2 percent) of the employee’s compensation for the plan year, or

(ii) an amount which is not less than the lesser of—

(I) 6 percent of the employee’s compensation for the plan year, or

(II) twice the amount of the salary reduction contributions of each qualified employee.

(B) MATCHING CONTRIBUTIONS ON BEHALF OF HIGHLY COMPENSATED AND KEY EMPLOYEES.—The requirements of subparagraph (A)(ii) shall not be treated as met if, under the plan, the rate of contributions with respect to any salary reduction contribution of a highly compensated or key employee at any rate of contribution is greater than that with respect to an employee who is not a highly compensated or key employee.

(C) ADDITIONAL CONTRIBUTIONS.—Subject to subparagraph (B), nothing in this paragraph shall be treated as prohibiting an employer from making contributions to pro-

vide qualified benefits under the plan in addition to contributions required under subparagraph (A).

(D) DEFINITIONS.—For purposes of this paragraph—

(i) SALARY REDUCTION CONTRIBUTION.—The term “salary reduction contribution” means, with respect to a cafeteria plan, any amount which is contributed to the plan at the election of the employee and which is not includible in gross income by reason of this section.

(ii) QUALIFIED EMPLOYEE.—The term “qualified employee” means, with respect to a cafeteria plan, any employee who is not a highly compensated or key employee and who is eligible to participate in the plan.

(iii) HIGHLY COMPENSATED EMPLOYEE.—The term “highly compensated employee” has the meaning given such term by section 414(q).

(iv) KEY EMPLOYEE.—The term “key employee” has the meaning given such term by section 416(i).

(4) MINIMUM ELIGIBILITY AND PARTICIPATION REQUIREMENTS.—

(A) IN GENERAL.—The requirements of this paragraph shall be treated as met with respect to any year if, under the plan—

(i) all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate, and

(ii) each employee eligible to participate in the plan may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan.

(B) CERTAIN EMPLOYEES MAY BE EXCLUDED.—For purposes of subparagraph (A)(i), an employer may elect to exclude under the plan employees—

(i) who have not attained the age of 21 before the close of a plan year,

(ii) who have less than 1 year of service with the employer as of any day during the plan year,

(iii) who are covered under an agreement which the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer, or

(iv) who are described in section 410(b)(3)(C) (relating to nonresident aliens working outside the United States).

A plan may provide a shorter period of service or younger age for purposes of clause (i) or (ii).

(5) ELIGIBLE EMPLOYER.—For purposes of this subsection—

(A) IN GENERAL.—The term “eligible employer” means, with respect to any year, any employer if such employer employed an average of 100 or fewer employees on business days during either of the 2 preceding years. For purposes of this subparagraph, a year may only be taken into

account if the employer was in existence throughout the year.

(B) EMPLOYERS NOT IN EXISTENCE DURING PRECEDING YEAR.—If an employer was not in existence throughout the preceding year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current year.

(C) GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.—

(i) IN GENERAL.—If—

(I) an employer was an eligible employer for any year (a “qualified year”), and

(II) such employer establishes a simple cafeteria plan for its employees for such year,

then, notwithstanding the fact the employer fails to meet the requirements of subparagraph (A) for any subsequent year, such employer shall be treated as an eligible employer for such subsequent year with respect to employees (whether or not employees during a qualified year) of any trade or business which was covered by the plan during any qualified year.

(ii) EXCEPTION.—This subparagraph shall cease to apply if the employer employs an average of 200 or more employees on business days during any year preceding any such subsequent year.

(D) SPECIAL RULES.—

(i) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

(ii) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (n) or (o) of section 414, shall be treated as one person.

(6) APPLICABLE NONDISCRIMINATION REQUIREMENT.—For purposes of this subsection, the term “applicable nondiscrimination requirement” means any requirement under subsection (b) of this section, section 79(d), section 105(h), or paragraph (2), (3), (4), or (8) of section 129(d).

(7) COMPENSATION.—The term “compensation” has the meaning given such term by section 414(s).

(k) CROSS REFERENCE.—For reporting and recordkeeping requirements, see section 6039D.

(l) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section.

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SEC. 139A. FEDERAL SUBSIDIES FOR PRESCRIPTION DRUG PLANS.

Gross income shall not include any special subsidy payment received under section 1860D-22 of the Social Security Act. *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.*

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PART VI—ITEMIZED DEDUCTIONS FOR INDIVIDUALS AND CORPORATIONS

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SEC. 162. TRADE OR BUSINESS EXPENSES.

(a) IN GENERAL.—There shall be allowed as a deduction all the ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business, including—

- (1) a reasonable allowance for salaries or other compensation for personal services actually rendered;
- (2) traveling expenses (including amounts expended for meals and lodging other than amounts which are lavish or extravagant under the circumstances) while away from home in the pursuit of a trade or business; and
- (3) rentals or other payments required to be made as a condition to the continued use or possession, for purposes of the trade or business, of property to which the taxpayer has not taken or is not taking title or in which he has no equity.

For purposes of the preceding sentence, the place of residence of a Member of Congress (including any Delegate and Resident Commissioner) within the State, congressional district, or possession which he represents in Congress shall be considered his home, but amounts expended by such Members within each taxable year for living expenses shall not be deductible for income tax purposes in excess of \$3,000. For purposes of paragraph (2), the taxpayer shall not be treated as being temporarily away from home during any period of employment if such period exceeds 1 year. The preceding sentence shall not apply to any Federal employee during any period for which such employee is certified by the Attorney General (or the designee thereof) as traveling on behalf of the United States in temporary duty status to investigate or prosecute, or provide support services for the investigation or prosecution of, a Federal crime.

(b) CHARITABLE CONTRIBUTIONS AND GIFTS EXCEPTED.—No deduction shall be allowed under subsection (a) for any contribution or gift which would be allowable as a deduction under section 170 were it not for the percentage limitations, the dollar limitations, or the requirements as to the time of payment, set forth in such section.

(c) ILLEGAL BRIBES, KICKBACKS, AND OTHER PAYMENTS.—

(1) ILLEGAL PAYMENTS TO GOVERNMENT OFFICIALS OR EMPLOYEES.—No deduction shall be allowed under subsection (a) for any payment made, directly or indirectly, to an official or employee of any government, or of any agency or instrumentality of any government, if the payment constitutes an illegal bribe or kickback or, if the payment is to an official or employee of a foreign government, the payment is unlawful under the Foreign Corrupt Practices Act of 1977. The burden of proof in respect of the issue, for the purposes of this paragraph, as to whether a payment constitutes an illegal bribe or kickback (or is unlawful under the Foreign Corrupt Practices Act of 1977) shall be upon the Secretary to the same extent as he bears the burden of proof under section 7454 (concerning the burden of proof when the issue relates to fraud).

(2) OTHER ILLEGAL PAYMENTS.—No deduction shall be allowed under subsection (a) for any payment (other than a payment described in paragraph (1)) made, directly or indirectly, to any person, if the payment constitutes an illegal bribe, illegal kickback, or other illegal payment under any law of the United States, or under any law of a State (but only if such State law is generally enforced), which subjects the payor to a criminal penalty or the loss of license or privilege to engage in a trade or business. For purposes of this paragraph, a kickback includes a payment in consideration of the referral of a client, patient, or customer. The burden of proof in respect of the issue, for purposes of this paragraph, as to whether a payment constitutes an illegal bribe, illegal kickback, or other illegal payment shall be upon the Secretary to the same extent as he bears the burden of proof under section 7454 (concerning the burden of proof when the issue relates to fraud).

(3) KICKBACKS, REBATES, AND BRIBES UNDER MEDICARE AND MEDICAID.—No deduction shall be allowed under subsection (a) for any kickback, rebate, or bribe made by any provider of services, supplier, physician, or other person who furnishes items or services for which payment is or may be made under the Social Security Act, or in whole or in part out of Federal funds under a State plan approved under such Act, if such kickback, rebate, or bribe is made in connection with the furnishing of such items or services or the making or receipt of such payments. For purposes of this paragraph, a kickback includes a payment in consideration of the referral of a client, patient, or customer.

(d) CAPITAL CONTRIBUTIONS TO FEDERAL NATIONAL MORTGAGE ASSOCIATION.—For purposes of this subtitle, whenever the amount of capital contributions evidenced by a share of stock issued pursuant to section 303(c) of the Federal National Mortgage Association Charter Act (12 U.S.C., sec. 1718) exceeds the fair market value of the stock as of the issue date of such stock, the initial holder of the stock shall treat the excess as ordinary and necessary expenses paid or incurred during the taxable year in carrying on a trade or business.

(e) DENIAL OF DEDUCTION FOR CERTAIN LOBBYING AND POLITICAL EXPENDITURES.—

(1) IN GENERAL.—No deduction shall be allowed under subsection (a) for any amount paid or incurred in connection with—

- (A) influencing legislation,
- (B) participation in, or intervention in, any political campaign on behalf of (or in opposition to) any candidate for public office,
- (C) any attempt to influence the general public, or segments thereof, with respect to elections, legislative matters, or referendums, or
- (D) any direct communication with a covered executive branch official in an attempt to influence the official actions or positions of such official.

(2) EXCEPTION FOR LOCAL LEGISLATION.—In the case of any legislation of any local council or similar governing body—

(A) paragraph (1)(A) shall not apply, and

(B) the deduction allowed by subsection (a) shall include all ordinary and necessary expenses (including, but not limited to, traveling expenses described in subsection (a)(2) and the cost of preparing testimony) paid or incurred during the taxable year in carrying on any trade or business—

(i) in direct connection with appearances before, submission of statements to, or sending communications to the committees, or individual members, of such council or body with respect to legislation or proposed legislation of direct interest to the taxpayer, or

(ii) in direct connection with communication of information between the taxpayer and an organization of which the taxpayer is a member with respect to any such legislation or proposed legislation which is of direct interest to the taxpayer and to such organization, and that portion of the dues so paid or incurred with respect to any organization of which the taxpayer is a member which is attributable to the expenses of the activities described in clauses (i) and (ii) carried on by such organization.

(3) APPLICATION TO DUES OF TAX-EXEMPT ORGANIZATIONS.—No deduction shall be allowed under subsection (a) for the portion of dues or other similar amounts paid by the taxpayer to an organization which is exempt from tax under this subtitle which the organization notifies the taxpayer under section 6033(e)(1)(A)(ii) is allocable to expenditures to which paragraph (1) applies.

(4) INFLUENCING LEGISLATION.—For purposes of this subsection—

(A) IN GENERAL.—The term “influencing legislation” means any attempt to influence any legislation through communication with any member or employee of a legislative body, or with any government official or employee who may participate in the formulation of legislation.

(B) LEGISLATION.—The term “legislation” has the meaning given such term by section 4911(e)(2).

(5) OTHER SPECIAL RULES.—

(A) EXCEPTION FOR CERTAIN TAXPAYERS.—In the case of any taxpayer engaged in the trade or business of conducting activities described in paragraph (1), paragraph (1) shall not apply to expenditures of the taxpayer in conducting such activities directly on behalf of another person (but shall apply to payments by such other person to the taxpayer for conducting such activities).

(B) DE MINIMIS EXCEPTION.—

(i) IN GENERAL.—Paragraph (1) shall not apply to any in-house expenditures for any taxable year if such expenditures do not exceed \$2,000. In determining whether a taxpayer exceeds the \$2,000 limit under this clause, there shall not be taken into account overhead costs otherwise allocable to activities described in paragraphs (1)(A) and (D).

(ii) IN-HOUSE EXPENDITURES.—For purposes of clause (i), the term “in-house expenditures” means expenditures described in paragraphs (1)(A) and (D) other than—

(I) payments by the taxpayer to a person engaged in the trade or business of conducting activities described in paragraph (1) for the conduct of such activities on behalf of the taxpayer, or

(II) dues or other similar amounts paid or incurred by the taxpayer which are allocable to activities described in paragraph (1).

(C) EXPENSES INCURRED IN CONNECTION WITH LOBBYING AND POLITICAL ACTIVITIES.—Any amount paid or incurred for research for, or preparation, planning, or coordination of, any activity described in paragraph (1) shall be treated as paid or incurred in connection with such activity.

(6) COVERED EXECUTIVE BRANCH OFFICIAL.—For purposes of this subsection, the term “covered executive branch official” means—

(A) the President,

(B) the Vice President,

(C) any officer or employee of the White House Office of the Executive Office of the President, and the 2 most senior level officers of each of the other agencies in such Executive Office, and

(D)(i) any individual serving in a position in level I of the Executive Schedule under section 5312 of title 5, United States Code, (ii) any other individual designated by the President as having Cabinet level status, and (iii) any immediate deputy of an individual described in clause (i) or (ii).

(7) SPECIAL RULE FOR INDIAN TRIBAL GOVERNMENTS.—For purposes of this subsection, an Indian tribal government shall be treated in the same manner as a local council or similar governing body.

(8) CROSS REFERENCE.—For reporting requirements and alternative taxes related to this subsection, see section 6033(e).

(f) FINES AND PENALTIES.—No deduction shall be allowed under subsection (a) for any fine or similar penalty paid to a government for the violation of any law.

(g) TREBLE DAMAGE PAYMENTS UNDER THE ANTITRUST LAWS.—If in a criminal proceeding a taxpayer is convicted of a violation of the antitrust laws, or his plea of guilty or nolo contendere to an indictment or information charging such a violation is entered or accepted in such a proceeding, no deduction shall be allowed under subsection (a) for two-thirds of any amount paid or incurred—

(1) on any judgment for damages entered against the taxpayer under section 4 of the Act entitled “An Act to supplement existing laws against unlawful restraints and monopolies, and for other purposes”, approved October 15, 1914 (commonly known as the Clayton Act), on account of such violation or any related violation of the antitrust laws which occurred prior to the date of the final judgment of such conviction, or

(2) in settlement of any action brought under such section 4 on account of such violation or related violation.

(h) STATE LEGISLATORS' TRAVEL EXPENSES AWAY FROM HOME.—

(1) IN GENERAL.—For purposes of subsection (a), in the case of any individual who is a State legislator at any time during the taxable year and who makes an election under this subsection for the taxable year—

(A) the place of residence of such individual within the legislative district which he represented shall be considered his home,

(B) he shall be deemed to have expended for living expenses (in connection with his trade or business as a legislator) an amount equal to the sum of the amounts determined by multiplying each legislative day of such individual during the taxable year by the greater of—

(i) the amount generally allowable with respect to such day to employees of the State of which he is a legislator for per diem while away from home, to the extent such amount does not exceed 110 percent of the amount described in clause (ii) with respect to such day, or

(ii) the amount generally allowable with respect to such day to employees of the executive branch of the Federal Government for per diem while away from home but serving in the United States, and

(C) he shall be deemed to be away from home in the pursuit of a trade or business on each legislative day.

(2) LEGISLATIVE DAYS.—For purposes of paragraph (1), a legislative day during any taxable year for any individual shall be any day during such year on which—

(A) the legislature was in session (including any day in which the legislature was not in session for a period of 4 consecutive days or less), or

(B) the legislature was not in session but the physical presence of the individual was formally recorded at a meeting of a committee of such legislature.

(3) ELECTION.—An election under this subsection for any taxable year shall be made at such time and in such manner as the Secretary shall by regulations prescribe.

(4) SECTION NOT TO APPLY TO LEGISLATORS WHO RESIDE NEAR CAPITOL.—This subsection shall not apply to any legislator whose place of residence within the legislative district which he represents is 50 or fewer miles from the capitol building of the State.

(j) CERTAIN FOREIGN ADVERTISING EXPENSES.—

(1) IN GENERAL.—No deduction shall be allowed under subsection (a) for any expenses of an advertisement carried by a foreign broadcast undertaking and directed primarily to a market in the United States. This paragraph shall apply only to foreign broadcast undertakings located in a country which denies a similar deduction for the cost of advertising directed primarily to a market in the foreign country when placed with a United States broadcast undertaking.

(2) BROADCAST UNDERTAKING.—For purposes of paragraph (1), the term “broadcast undertaking” includes (but is not limited to) radio and television stations.

(k) STOCK REACQUISITION EXPENSES.—

(1) IN GENERAL.—Except as provided in paragraph (2), no deduction otherwise allowable shall be allowed under this chapter for any amount paid or incurred by a corporation in connection with the reacquisition of its stock or of the stock of any related person (as defined in section 465(b)(3)(C)).

(2) EXCEPTIONS.—Paragraph (1) shall not apply to—

(A) CERTAIN SPECIFIC DEDUCTIONS.—Any—

(i) deduction allowable under section 163 (relating to interest),

(ii) deduction for amounts which are properly allocable to indebtedness and amortized over the term of such indebtedness, or

(iii) deduction for dividends paid (within the meaning of section 561).

(B) STOCK OF CERTAIN REGULATED INVESTMENT COMPANIES.—Any amount paid or incurred in connection with the redemption of any stock in a regulated investment company which issues only stock which is redeemable upon the demand of the shareholder.

(l) SPECIAL RULES FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—

(1) ALLOWANCE OF DEDUCTION.—In the case of a taxpayer who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the amount paid during the taxable year for insurance which constitutes medical care for—

(A) the taxpayer,

(B) the taxpayer’s spouse,

(C) the taxpayer’s dependents, and

(D) 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.

(2) LIMITATIONS.—

(A) DOLLAR AMOUNT.—No deduction shall be allowed under paragraph (1) to the extent that the amount of such deduction exceeds the taxpayer’s earned income (within the meaning of section 401(c)) derived by the taxpayer from the trade or business with respect to which the plan providing the medical care coverage is established.

(B) OTHER COVERAGE.—Paragraph (1) shall not apply to any taxpayer for any calendar month for which the taxpayer is eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or of the spouse of, or any dependent, or individual described in subparagraph (D) of paragraph (1) with respect to, the taxpayer. The preceding sentence shall be applied separately with respect to—

(i) plans which include coverage for qualified long-term care services (as defined in section 7702B(c)) or

are qualified long-term care insurance contracts (as defined in section 7702B(b)), and

(ii) plans which do not include such coverage and are not such contracts.

(C) LONG-TERM CARE PREMIUMS.—In the case of a qualified long-term care insurance contract (as defined in section 7702B(b)), only eligible long-term care premiums (as defined in section 213(d)(10)) shall be taken into account under paragraph (1).

(3) COORDINATION WITH MEDICAL DEDUCTION.—Any amount paid by a taxpayer for insurance to which paragraph (1) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a).

(4) DEDUCTION NOT ALLOWED FOR SELF-EMPLOYMENT TAX PURPOSES.—The deduction allowable by reason of this subsection shall not be taken into account in determining an individual's net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2 for taxable years beginning before January 1, 2010, or after December 31, 2010.

(5) TREATMENT OF CERTAIN S CORPORATION SHAREHOLDERS.—This subsection shall apply in the case of any individual treated as a partner under section 1372(a), except that—

(A) for purposes of this subsection, such individual's wages (as defined in section 3121) from the S corporation shall be treated as such individual's earned income (within the meaning of section 401(c)(1)), and

(B) there shall be such adjustments in the application of this subsection as the Secretary may by regulations prescribe.

(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 (i)(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.

(m) CERTAIN EXCESSIVE EMPLOYEE REMUNERATION.—

(1) IN GENERAL.—In the case of any publicly held corporation, no deduction shall be allowed under this chapter for applicable employee remuneration with respect to any covered employee to the extent that the amount of such remuneration for the taxable year with respect to such employee exceeds \$1,000,000.

(2) PUBLICLY HELD CORPORATION.—For purposes of this subsection, the term “publicly held corporation” means any corporation issuing any class of common equity securities required to be registered under section 12 of the Securities Exchange Act of 1934.

(3) COVERED EMPLOYEE.—For purposes of this subsection, the term “covered employee” means any employee of the taxpayer if—

(A) as of the close of the taxable year, such employee is the chief executive officer of the taxpayer or is an individual acting in such a capacity, or

(B) the total compensation of such employee for the taxable year is required to be reported to shareholders under the Securities Exchange Act of 1934 by reason of such employee being among the 4 highest compensated officers for the taxable year (other than the chief executive officer).

(4) APPLICABLE EMPLOYEE REMUNERATION.—For purposes of this subsection—

(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term “applicable employee remuneration” means, with respect to any covered employee for any taxable year, the aggregate amount allowable as a deduction under this chapter for such taxable year (determined without regard to this subsection) for remuneration for services performed by such employee (whether or not during the taxable year).

(B) EXCEPTION FOR REMUNERATION PAYABLE ON COMMISSION BASIS.—The term “applicable employee remuneration” shall not include any remuneration payable on a commission basis solely on account of income generated directly by the individual performance of the individual to whom such remuneration is payable.

(C) OTHER PERFORMANCE-BASED COMPENSATION.—The term “applicable employee remuneration” shall not include any remuneration payable solely on account of the attainment of one or more performance goals, but only if—

(i) the performance goals are determined by a compensation committee of the board of directors of the taxpayer which is comprised solely of 2 or more outside directors,

(ii) the material terms under which the remuneration is to be paid, including the performance goals, are disclosed to shareholders and approved by a majority of the vote in a separate shareholder vote before the payment of such remuneration, and

(iii) before any payment of such remuneration, the compensation committee referred to in clause (i) certifies that the performance goals and any other material terms were in fact satisfied.

(D) EXCEPTION FOR EXISTING BINDING CONTRACTS.—The term “applicable employee remuneration” shall not include any remuneration payable under a written binding contract which was in effect on February 17, 1993, and which was not modified thereafter in any material respect before such remuneration is paid.

(E) REMUNERATION.—For purposes of this paragraph, the term “remuneration” includes any remuneration (including benefits) in any medium other than cash, but shall not include—

- (i) any payment referred to in so much of section 3121(a)(5) as precedes subparagraph (E) thereof, and
- (ii) any benefit provided to or on behalf of an employee if at the time such benefit is provided it is reasonable to believe that the employee will be able to exclude such benefit from gross income under this chapter.

For purposes of clause (i), section 3121(a)(5) shall be applied without regard to section 3121(v)(1).

(F) COORDINATION WITH DISALLOWED GOLDEN PARACHUTE PAYMENTS.—The dollar limitation contained in paragraph (1) shall be reduced (but not below zero) by the amount (if any) which would have been included in the applicable employee remuneration of the covered employee for the taxable year but for being disallowed under section 280G.

(G) COORDINATION WITH EXCISE TAX ON SPECIFIED STOCK COMPENSATION.—The dollar limitation contained in paragraph (1) with respect to any covered employee shall be reduced (but not below zero) by the amount of any payment (with respect to such employee) of the tax imposed by section 4985 directly or indirectly by the expatriated corporation (as defined in such section) or by any member of the expanded affiliated group (as defined in such section) which includes such corporation.

(5) SPECIAL RULE FOR APPLICATION TO EMPLOYERS PARTICIPATING IN THE TROUBLED ASSETS RELIEF PROGRAM.—

(A) IN GENERAL.—In the case of an applicable employer, no deduction shall be allowed under this chapter—

- (i) in the case of executive remuneration for any applicable taxable year which is attributable to services performed by a covered executive during such applicable taxable year, to the extent that the amount of such remuneration exceeds \$500,000, or
- (ii) in the case of deferred deduction executive remuneration for any taxable year for services performed during any applicable taxable year by a covered executive, to the extent that the amount of such remuneration exceeds \$500,000 reduced (but not below zero) by the sum of—

(I) the executive remuneration for such applicable taxable year, plus

(II) the portion of the deferred deduction executive remuneration for such services which was taken into account under this clause in a preceding taxable year.

(B) APPLICABLE EMPLOYER.—For purposes of this paragraph—

- (i) IN GENERAL.—Except as provided in clause (ii), the term “applicable employer” means any employer from whom 1 or more troubled assets are acquired under a program established by the Secretary under section 101(a) of the Emergency Economic Stabilization Act of 2008 if the aggregate amount of the assets so acquired for all taxable years exceeds \$300,000,000.

(ii) **DISREGARD OF CERTAIN ASSETS SOLD THROUGH DIRECT PURCHASE.**—If the only sales of troubled assets by an employer under the program described in clause (i) are through 1 or more direct purchases (within the meaning of section 113(c) of the Emergency Economic Stabilization Act of 2008), such assets shall not be taken into account under clause (i) in determining whether the employer is an applicable employer for purposes of this paragraph.

(iii) **AGGREGATION RULES.**—Two or more persons who are treated as a single employer under subsection (b) or (c) of section 414 shall be treated as a single employer, except that in applying section 1563(a) for purposes of either such subsection, paragraphs (2) and (3) thereof shall be disregarded.

(C) **APPLICABLE TAXABLE YEAR.**—For purposes of this paragraph, the term “applicable taxable year” means, with respect to any employer—

(i) the first taxable year of the employer—

(I) which includes any portion of the period during which the authorities under section 101(a) of the Emergency Economic Stabilization Act of 2008 are in effect (determined under section 120 thereof), and

(II) in which the aggregate amount of troubled assets acquired from the employer during the taxable year pursuant to such authorities (other than assets to which subparagraph (B)(ii) applies), when added to the aggregate amount so acquired for all preceding taxable years, exceeds \$300,000,000, and

(ii) any subsequent taxable year which includes any portion of such period.

(D) **COVERED EXECUTIVE.**—For purposes of this paragraph—

(i) **IN GENERAL.**—The term “covered executive” means, with respect to any applicable taxable year, any employee—

(I) who, at any time during the portion of the taxable year during which the authorities under section 101(a) of the Emergency Economic Stabilization Act of 2008 are in effect (determined under section 120 thereof), is the chief executive officer of the applicable employer or the chief financial officer of the applicable employer, or an individual acting in either such capacity, or

(II) who is described in clause (ii).

(ii) **HIGHEST COMPENSATED EMPLOYEES.**—An employee is described in this clause if the employee is 1 of the 3 highest compensated officers of the applicable employer for the taxable year (other than an individual described in clause (i)(I)), determined—

(I) on the basis of the shareholder disclosure rules for compensation under the Securities Ex-

change Act of 1934 (without regard to whether those rules apply to the employer), and

(II) by only taking into account employees employed during the portion of the taxable year described in clause (i)(I).

(iii) **EMPLOYEE REMAINS COVERED EXECUTIVE.**—If an employee is a covered executive with respect to an applicable employer for any applicable taxable year, such employee shall be treated as a covered executive with respect to such employer for all subsequent applicable taxable years and for all subsequent taxable years in which deferred deduction executive remuneration with respect to services performed in all such applicable taxable years would (but for this paragraph) be deductible.

(E) **EXECUTIVE REMUNERATION.**—For purposes of this paragraph, the term “executive remuneration” means the applicable employee remuneration of the covered executive, as determined under paragraph (4) without regard to subparagraphs (B), (C), and (D) thereof. Such term shall not include any deferred deduction executive remuneration with respect to services performed in a prior applicable taxable year.

(F) **DEFERRED DEDUCTION EXECUTIVE REMUNERATION.**—For purposes of this paragraph, the term “deferred deduction executive remuneration” means remuneration which would be executive remuneration for services performed in an applicable taxable year but for the fact that the deduction under this chapter (determined without regard to this paragraph) for such remuneration is allowable in a subsequent taxable year.

(G) **COORDINATION.**—Rules similar to the rules of subparagraphs (F) and (G) of paragraph (4) shall apply for purposes of this paragraph.

(H) **REGULATORY AUTHORITY.**—The Secretary may prescribe such guidance, rules, or regulations as are necessary to carry out the purposes of this paragraph and the Emergency Economic Stabilization Act of 2008, including the extent to which this paragraph applies in the case of any acquisition, merger, or reorganization of an applicable employer.

(6) **SPECIAL RULE FOR APPLICATION TO CERTAIN HEALTH INSURANCE PROVIDERS.**—

(A) **IN GENERAL.**—No deduction shall be allowed under this chapter—

(i) in the case of applicable individual remuneration which is for any disqualified taxable year beginning after December 31, 2012, and which is attributable to services performed by an applicable individual during such taxable year, to the extent that the amount of such remuneration exceeds \$500,000, or

(ii) in the case of deferred deduction remuneration for any taxable year beginning after December 31, 2012, which is attributable to services performed by

an applicable individual during any disqualified taxable year beginning after December 31, 2009, to the extent that the amount of such remuneration exceeds \$500,000 reduced (but not below zero) by the sum of—

(I) the applicable individual remuneration for such disqualified taxable year, plus

(II) the portion of the deferred deduction remuneration for such services which was taken into account under this clause in a preceding taxable year (or which would have been taken into account under this clause in a preceding taxable year if this clause were applied by substituting ‘December 31, 2009’ for ‘December 31, 2012’ in the matter preceding subclause (I)).

(B) **DISQUALIFIED TAXABLE YEAR.**—For purposes of this paragraph, the term “disqualified taxable year” means, with respect to any employer, any taxable year for which such employer is a covered health insurance provider.

(C) **COVERED HEALTH INSURANCE PROVIDER.**—For purposes of this paragraph—

(i) **IN GENERAL.**—The term “covered health insurance provider” means—

(I) with respect to taxable years beginning after December 31, 2009, and before January 1, 2013, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and which receives premiums from providing health insurance coverage (as defined in section 9832(b)(1)), and

(II) with respect to taxable years beginning after December 31, 2012, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and with respect to which not less than 25 percent of the gross premiums received from providing health insurance coverage (as defined in section 9832(b)(1)) is from minimum essential coverage (as defined in section 5000A(f)).

(ii) **AGGREGATION RULES.**—Two or more persons who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer, except that in applying section 1563(a) for purposes of any such subsection, paragraphs (2) and (3) thereof shall be disregarded.

(D) **APPLICABLE INDIVIDUAL REMUNERATION.**—For purposes of this paragraph, the term “applicable individual remuneration” means, with respect to any applicable individual for any disqualified taxable year, the aggregate amount allowable as a deduction under this chapter for such taxable year (determined without regard to this subsection) for remuneration (as defined in paragraph (4) without regard to subparagraphs (B), (C), and (D) thereof) for services performed by such individual (whether or not during the taxable year). Such term shall not include any deferred deduction remuneration with respect to services performed during the disqualified taxable year.

(E) DEFERRED DEDUCTION REMUNERATION.—For purposes of this paragraph, the term “deferred deduction remuneration” means remuneration which would be applicable individual remuneration for services performed in a disqualified taxable year but for the fact that the deduction under this chapter (determined without regard to this paragraph) for such remuneration is allowable in a subsequent taxable year.

(F) APPLICABLE INDIVIDUAL.—For purposes of this paragraph, the term “applicable individual” means, with respect to any covered health insurance provider for any disqualified taxable year, any individual—

(i) who is an officer, director, or employee in such taxable year, or

(ii) who provides services for or on behalf of such covered health insurance provider during such taxable year.

(G) COORDINATION.—Rules similar to the rules of subparagraphs (F) and (G) of paragraph (4) shall apply for purposes of this paragraph.

(H) REGULATORY AUTHORITY.—The Secretary may prescribe such guidance, rules, or regulations as are necessary to carry out the purposes of this paragraph.

(I) TERMINATION.—*This paragraph shall not apply to taxable years beginning after December 31, 2017.*

(n) SPECIAL RULE FOR CERTAIN GROUP HEALTH PLANS.—

(1) IN GENERAL.—No deduction shall be allowed under this chapter to an employer for any amount paid or incurred in connection with a group health plan if the plan does not reimburse for inpatient hospital care services provided in the State of New York—

(A) except as provided in subparagraphs (B) and (C), at the same rate as licensed commercial insurers are required to reimburse hospitals for such services when such reimbursement is not through such a plan,

(B) in the case of any reimbursement through a health maintenance organization, at the same rate as health maintenance organizations are required to reimburse hospitals for such services for individuals not covered by such a plan (determined without regard to any government-supported individuals exempt from such rate), or

(C) in the case of any reimbursement through any corporation organized under Article 43 of the New York State Insurance Law, at the same rate as any such corporation is required to reimburse hospitals for such services for individuals not covered by such a plan.

(2) STATE LAW EXCEPTION.—Paragraph (1) shall not apply to any group health plan which is not required under the laws of the State of New York (determined without regard to this subsection or other provisions of Federal law) to reimburse at the rates provided in paragraph (1).

(3) GROUP HEALTH PLAN.—For purposes of this subsection, the term “group health plan” means a plan of, or contributed to by, an employer or employee organization (including a self-

insured plan) to provide health care (directly or otherwise) to any employee, any former employee, the employer, or any other individual associated or formerly associated with the employer in a business relationship, or any member of their family.

(o) TREATMENT OF CERTAIN EXPENSES OF RURAL MAIL CARRIERS.—

(1) GENERAL RULE.—In the case of any employee of the United States Postal Service who performs services involving the collection and delivery of mail on a rural route and who receives qualified reimbursements for the expenses incurred by such employee for the use of a vehicle in performing such services—

(A) the amount allowable as a deduction under this chapter for the use of a vehicle in performing such services shall be equal to the amount of such qualified reimbursements; and

(B) such qualified reimbursements shall be treated as paid under a reimbursement or other expense allowance arrangement for purposes of section 62(a)(2)(A) (and section 62(c) shall not apply to such qualified reimbursements).

(2) SPECIAL RULE WHERE EXPENSES EXCEED REIMBURSEMENTS.—Notwithstanding paragraph (1)(A), if the expenses incurred by an employee for the use of a vehicle in performing services described in paragraph (1) exceed the qualified reimbursements for such expenses, such excess shall be taken into account in computing the miscellaneous itemized deductions of the employee under section 67.

(3) DEFINITION OF QUALIFIED REIMBURSEMENTS.—For purposes of this subsection, the term “qualified reimbursements” means the amounts paid by the United States Postal Service to employees as an equipment maintenance allowance under the 1991 collective bargaining agreement between the United States Postal Service and the National Rural Letter Carriers’ Association. Amounts paid as an equipment maintenance allowance by such Postal Service under later collective bargaining agreements that supersede the 1991 agreement shall be considered qualified reimbursements if such amounts do not exceed the amounts that would have been paid under the 1991 agreement, adjusted for changes in the Consumer Price Index (as defined in section 1(f)(5)) since 1991.

(p) TREATMENT OF EXPENSES OF MEMBERS OF RESERVE COMPONENT OF ARMED FORCES OF THE UNITED STATES.—For purposes of subsection (a)(2), in the case of an individual who performs services as a member of a reserve component of the Armed Forces of the United States at any time during the taxable year, such individual shall be deemed to be away from home in the pursuit of a trade or business for any period during which such individual is away from home in connection with such service.

(q) CROSS REFERENCE.—

(1) For special rule relating to expenses in connection with subdividing real property for sale, see section 1237.

(2) For special rule relating to the treatment of payments by a transferee of a franchise, trademark, or trade name, see section 1253.

(3) For special rules relating to—

(A) funded welfare benefit plans, see section 419, and

(B) deferred compensation and other deferred benefits, see section 404.

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PART VII—ADDITIONAL ITEMIZED DEDUCTIONS FOR INDIVIDUALS

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SEC. 213. MEDICAL, DENTAL, ETC., EXPENSES.

(a) ALLOWANCE OF DEDUCTION.—There shall be allowed as a deduction the expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof), to the extent that such expenses exceed **10 percent** 7.5 percent of adjusted gross income.

(b) LIMITATION WITH RESPECT TO MEDICINE AND DRUGS.—An amount paid during the taxable year for medicine or a drug shall be taken into account under subsection (a) only if such medicine or drug is a prescribed drug or is insulin.

(c) SPECIAL RULE FOR DECEDENTS.—

(1) TREATMENT OF EXPENSES PAID AFTER DEATH.—For purposes of subsection (a), expenses for the medical care of the taxpayer which are paid out of his estate during the 1-year period beginning with the day after the date of his death shall be treated as paid by the taxpayer at the time incurred.

(2) LIMITATION.—Paragraph (1) shall not apply if the amount paid is allowable under section 2053 as a deduction in computing the taxable estate of the decedent, but this paragraph shall not apply if (within the time and in the manner and form prescribed by the Secretary) there is filed—

(A) a statement that such amount has not been allowed as a deduction under section 2053, and

(B) a waiver of the right to have such amount allowed at any time as a deduction under section 2053.

(d) DEFINITIONS.—For purposes of this section—

(1) The term “medical care” means amounts paid—

(A) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,

(B) for transportation primarily for and essential to medical care referred to in subparagraph (A),

(C) for qualified long-term care services (as defined in section 7702B(c)), or

(D) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care referred to in subparagraphs (A) and

(B) or for any qualified long-term care insurance contract (as defined in section 7702B(b)).

In the case of a qualified long-term care insurance contract (as defined in section 7702B(b)), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D).

(2) Amounts paid for certain lodging away from home treated as paid for medical care

Amounts paid for lodging (not lavish or extravagant under the circumstances) while away from home primarily for and essential to medical care referred to in paragraph (1)(A) shall be treated as amounts paid for medical care if—

(A) the medical care referred to in paragraph (1)(A) is provided by a physician in a licensed hospital (or in a medical care facility which is related to, or the equivalent of, a licensed hospital), and

(B) there is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

The amount taken into account under the preceding sentence shall not exceed \$50 for each night for each individual.

(3) Prescribed drug

The term “prescribed drug” means a drug or biological which requires a prescription of a physician for its use by an individual.

(4) Physician

The term “physician” has the meaning given to such term by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

(5) Special rule in the case of child of divorced parents, etc.

Any child to whom section 152(e) applies shall be treated as a dependent of both parents for purposes of this section.

(6) In the case of an insurance contract under which amounts are payable for other than medical care referred to in subparagraphs (A), (B), and (C) of paragraph (1)—

(A) no amount shall be treated as paid for insurance to which paragraph (1)(D) applies unless the charge for such insurance is either separately stated in the contract, or furnished to the policyholder by the insurance company in a separate statement,

(B) the amount taken into account as the amount paid for such insurance shall not exceed such charge, and

(C) no amount shall be treated as paid for such insurance if the amount specified in the contract (or furnished to the policyholder by the insurance company in a separate statement) as the charge for such insurance is unreasonably large in relation to the total charges under the contract.

(7) Subject to the limitations of paragraph (6), premiums paid during the taxable year by a taxpayer before he attains the age of 65 for insurance covering medical care (within the meaning of subparagraphs (A), (B), and (C) of paragraph (1)) for the taxpayer, his spouse, or a dependent after the taxpayer attains the age of 65 shall be treated as expenses paid during the taxable year for insurance which constitutes medical care if premiums for such insurance are payable (on a level pay-

ment basis) under the contract for a period of 10 years or more or until the year in which the taxpayer attains the age of 65 (but in no case for a period of less than 5 years).

(8) The determination of whether an individual is married at any time during the taxable year shall be made in accordance with the provisions of section 6013(d) (relating to determination of status as husband and wife).

(9) COSMETIC SURGERY.—

(A) IN GENERAL.—The term “medical care” does not include cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.

(B) COSMETIC SURGERY DEFINED.—For purposes of this paragraph, the term “cosmetic surgery” means any procedure which is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

(10) ELIGIBLE LONG-TERM CARE PREMIUMS.—

(A) IN GENERAL.—For purposes of this section, the term “eligible long-term care Premiums” means the amount paid during a taxable year for any qualified long-term care insurance contract (as defined in section 7702B(b)) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

In the case of an individual with an attained age before the close of the taxable year of:	The limitation is:
40 or less	\$200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	2,000
More than 70	2,500

(B) INDEXING.—

(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount contained in subparagraph (A) shall be increased by the medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of \$10, such increase shall be rounded to the nearest multiple of \$10.

(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

(I) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

(II) such component for August of 1996.

The Secretary shall, in consultation with the Secretary of Health and Human Services, prescribe an adjust-

ment which the Secretary determines is more appropriate for purposes of this paragraph than the adjustment described in the preceding sentence, and the adjustment so prescribed shall apply in lieu of the adjustment described in the preceding sentence.

(11) Certain payments to relatives treated as not paid for medical care --An amount paid for a qualified long-term care service (as defined in section 7702B(c)) provided to an individual shall be treated as not paid for medical care if such service is provided—

(A) by the spouse of the individual or by a relative (directly or through a partnership, corporation, or other entity) unless the service is provided by a licensed professional with respect to such service, or

(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term “relative” means an individual bearing a relationship to the individual which is described in any of subparagraphs (A) through (G) of section 152(d)(2). This paragraph shall not apply for purposes of section 105(b) with respect to reimbursements through insurance.

(e) EXCLUSION OF AMOUNTS ALLOWED FOR CARE OF CERTAIN DEPENDENTS.—Any expense allowed as a credit under section 21 shall not be treated as an expense paid for medical care.

(f) SPECIAL RULE FOR 2013, 2014, 2015, [AND 2016] 2016, AND 2017.—In the case of any taxable year beginning after December 31, 2012, and ending before January 1, [2017] 2018, subsection (a) shall be applied with respect to a taxpayer by substituting “7.5 percent” for “10 percent” if such taxpayer or such taxpayer’s spouse has attained age 65 before the close of such taxable year.

* * * * *

SEC. 220. ARCHER MSAS.

(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to an Archer MSA of such individual.

(b) LIMITATIONS.—

(1) IN GENERAL.—The amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year that the individual is an eligible individual.

(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/12 of—

(A) in the case of an individual who has self-only coverage under the high deductible health plan as of the first day of such month, 65 percent of the annual deductible under such coverage, and

(B) in the case of an individual who has family coverage under the high deductible health plan as of the first day

of such month, 75 percent of the annual deductible under such coverage.

(3) SPECIAL RULE FOR MARRIED INDIVIDUALS.—In the case of individuals who are married to each other, if either spouse has family coverage—

(A) both spouses shall be treated as having only such family coverage (and if such spouses each have family coverage under different plans, as having the family coverage with the lowest annual deductible), and

(B) the limitation under paragraph (1) (after the application of subparagraph (A) of this paragraph) shall be divided equally between them unless they agree on a different division.

(4) DEDUCTION NOT TO EXCEED COMPENSATION.—

(A) EMPLOYEES.—The deduction allowed under subsection (a) for contributions as an eligible individual described in subclause (I) of subsection (c)(1)(A)(iii) shall not exceed such individual's wages, salaries, tips, and other employee compensation which are attributable to such individual's employment by the employer referred to in such subclause.

(B) SELF-EMPLOYED INDIVIDUALS.—The deduction allowed under subsection (a) for contributions as an eligible individual described in subclause (II) of subsection (c)(1)(A)(iii) shall not exceed such individual's earned income (as defined in section 401(c)(1)) derived by the taxpayer from the trade or business with respect to which the high deductible health plan is established.

(C) COMMUNITY PROPERTY LAWS NOT TO APPLY.—The limitations under this paragraph shall be determined without regard to community property laws.

(5) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—No deduction shall be allowed under this section for any amount paid for any taxable year to an Archer MSA of an individual if—

(A) any amount is contributed to any Archer MSA of such individual for such year which is excludable from gross income under section 106(b), or

(B) if such individual's spouse is covered under the high deductible health plan covering such individual, any amount is contributed for such year to any Archer MSA of such spouse which is so excludable.

(6) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

(7) MEDICARE ELIGIBLE INDIVIDUALS.—The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.

(c) DEFINITIONS.—For purposes of this section—

(1) ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—The term “eligible individual” means, with respect to any month, any individual if—

(i) such individual is covered under a high deductible health plan as of the 1st day of such month,

(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

(I) which is not a high deductible health plan, and

(II) which provides coverage for any benefit which is covered under the high deductible health plan, and

(iii)

(I) the high deductible health plan covering such individual is established and maintained by the employer of such individual or of the spouse of such individual and such employer is a small employer, or

(II) such individual is an employee (within the meaning of section 401(c)(1)) or the spouse of such an employee and the high deductible health plan covering such individual is not established or maintained by any employer of such individual or spouse.

(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph

(A)(ii) shall be applied without regard to—

(i) coverage for any benefit provided by permitted insurance, and

(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

(C) CONTINUED ELIGIBILITY OF EMPLOYEE AND SPOUSE ESTABLISHING ARCHER MSAS.—If, while an employer is a small employer—

(i) any amount is contributed to an Archer MSA of an individual who is an employee of such employer or the spouse of such an employee, and

(ii) such amount is excludable from gross income under section 106(b) or allowable as a deduction under this section,

such individual shall not cease to meet the requirement of subparagraph (A)(iii)(I) by reason of such employer ceasing to be a small employer so long as such employee continues to be an employee of such employer.

(D) LIMITATIONS ON ELIGIBILITY.—For limitations on number of taxpayers who are eligible to have Archer MSAs, see subsection (i).

(2) HIGH DEDUCTIBLE HEALTH PLAN.—

(A) IN GENERAL.—The term “high deductible health plan” means a health plan—

(i) in the case of self-only coverage, which has an annual deductible which is not less than \$1,500 and not more than \$2,250,

(ii) in the case of family coverage, which has an annual deductible which is not less than \$3,000 and not more than \$4,500, and

(iii) the annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—

(I) \$3,000 for self-only coverage, and

(II) \$5,500 for family coverage.

(B) SPECIAL RULES.—

(i) EXCLUSION OF CERTAIN PLANS.—Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B).

(ii) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care if the absence of a deductible for such care is required by State law.

(3) PERMITTED INSURANCE.—The term “permitted insurance” means—

(A) insurance if substantially all of the coverage provided under such insurance relates to—

(i) liabilities incurred under workers’ compensation laws,

(ii) tort liabilities,

(iii) liabilities relating to ownership or use of property, or

(iv) such other similar liabilities as the Secretary may specify by regulations,

(B) insurance for a specified disease or illness, and

(C) insurance paying a fixed amount per day (or other period) of hospitalization.

(4) SMALL EMPLOYER.—

(A) IN GENERAL.—The term “small employer” means, with respect to any calendar year, any employer if such employer employed an average of 50 or fewer employees on business days during either of the 2 preceding calendar years. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the employer was in existence throughout such year.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the 1st preceding calendar year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) CERTAIN GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.—The term “small employer” includes, with respect to any calendar year, any employer if—

(i) such employer met the requirement of subparagraph (A) (determined without regard to subparagraph (B)) for any preceding calendar year after 1996,

(ii) any amount was contributed to the Archer MSA of any employee of such employer with respect to cov-

erage of such employee under a high deductible health plan of such employer during such preceding calendar year and such amount was excludable from gross income under section 106(b) or allowable as a deduction under this section, and

(iii) such employer employed an average of 200 or fewer employees on business days during each preceding calendar year after 1996.

(D) SPECIAL RULES.—

(i) CONTROLLED GROUPS.—For purposes of this paragraph, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer.

(ii) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

(5) FAMILY COVERAGE.—The term “family coverage” means any coverage other than self-only coverage.

(d) ARCHER MSA.—For purposes of this section—

(1) ARCHER MSA.—The term “Archer MSA” means a trust created or organized in the United States as a medical savings account exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

(A) Except in the case of a rollover contribution described in subsection (f)(5), no contribution will be accepted—

(i) unless it is in cash, or

(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds 75 percent of the highest annual limit deductible permitted under subsection (c)(2)(A)(ii) for such calendar year.

(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

(C) No part of the trust assets will be invested in life insurance contracts.

(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

(E) The interest of an individual in the balance in his account is nonforfeitable.

(2) QUALIFIED MEDICAL EXPENSES.—

(A) IN GENERAL.—The term “qualified medical expenses” means, with respect to an account holder, amounts paid by such holder for medical care (as defined in section 213(d)) for such individual, the spouse of such individual, and any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of

such individual, but only to the extent such amounts are not compensated for by insurance or otherwise. [Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.]

(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—

(i) IN GENERAL.—Subparagraph (A) shall not apply to any payment for insurance.

(ii) EXCEPTIONS.—Clause (i) shall not apply to any expense for coverage under—

(I) a health plan during any period of continuation coverage required under any Federal law,

(II) a qualified long-term care insurance contract (as defined in section 7702B(b)), or

(III) a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law.

(C) MEDICAL EXPENSES OF INDIVIDUALS WHO ARE NOT ELIGIBLE INDIVIDUALS.—Subparagraph (A) shall apply to an amount paid by an account holder for medical care of an individual who is not described in clauses (i) and (ii) of subsection (c)(1)(A) for the month in which the expense for such care is incurred only if no amount is contributed (other than a rollover contribution) to any Archer MSA of such account holder for the taxable year which includes such month. This subparagraph shall not apply to any expense for coverage described in subclause (I) or (III) of subparagraph (B)(ii).

(3) ACCOUNT HOLDER.—The term “account holder” means the individual on whose behalf the Archer MSA was established.

(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

(A) Section 219(d)(2) (relating to no deduction for rollovers).

(B) Section 219(f)(3) (relating to time when contributions deemed made).

(C) Except as provided in section 106(b), section 219(f)(5) (relating to employer payments).

(D) Section 408(g) (relating to community property laws).

(E) Section 408(h) (relating to custodial accounts).

(e) TAX TREATMENT OF ACCOUNTS.—

(1) IN GENERAL.—An Archer MSA is exempt from taxation under this subtitle unless such account has ceased to be an Archer MSA. Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to Archer MSAs, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

(f) TAX TREATMENT OF DISTRIBUTIONS.—

(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of an Archer MSA which is used exclusively to pay qualified medical expenses of any account holder shall not be includible in gross income.

(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of an Archer MSA which is not used exclusively to pay the qualified medical expenses of the account holder shall be included in the gross income of such holder.

(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—

(A) IN GENERAL.—If any excess contribution is contributed for a taxable year to any Archer MSA of an individual, paragraph (2) shall not apply to distributions from the Archer MSAs of such individual (to the extent such distributions do not exceed the aggregate excess contributions to all such accounts of such individual for such year) if—

(i) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

(ii) such distribution is accompanied by the amount of net income attributable to such excess contribution. Any net income described in clause (ii) shall be included in the gross income of the individual for the taxable year in which it is received.

(B) EXCESS CONTRIBUTION.—For purposes of subparagraph (A), the term “excess contribution” means any contribution (other than a rollover contribution) which is neither excludable from gross income under section 106(b) nor deductible under this section.

(4) ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

(A) IN GENERAL.—The tax imposed by this chapter on the account holder for any taxable year in which there is a payment or distribution from an Archer MSA of such holder which is includible in gross income under paragraph (2) shall be increased by ~~20 percent~~ 15 percent of the amount which is so includible.

(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account holder becomes disabled within the meaning of section 72(m)(7) or dies.

(C) EXCEPTION FOR DISTRIBUTIONS AFTER MEDICARE ELIGIBILITY.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account holder attains the age specified in section 1811 of the Social Security Act.

(5) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from an Archer MSA to the ac-

count holder to the extent the amount received is paid into an Archer MSA or a health savings account (as defined in section 223(d)) for the benefit of such holder not later than the 60th day after the day on which the holder receives the payment or distribution.

(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from an Archer MSA if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from an Archer MSA which was not includible in the individual's gross income because of the application of this paragraph.

(6) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of determining the amount of the deduction under section 213, any payment or distribution out of an Archer MSA for qualified medical expenses shall not be treated as an expense paid for medical care.

(7) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in an Archer MSA to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as an Archer MSA with respect to which such spouse is the account holder.

(8) TREATMENT AFTER DEATH OF ACCOUNT HOLDER.—

(A) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—If the account holder's surviving spouse acquires such holder's interest in an Archer MSA by reason of being the designated beneficiary of such account at the death of the account holder, such Archer MSA shall be treated as if the spouse were the account holder.

(B) OTHER CASES.—

(i) IN GENERAL.—If, by reason of the death of the account holder, any person acquires the account holder's interest in an Archer MSA in a case to which subparagraph (A) does not apply—

(I) such account shall cease to be an Archer MSA as of the date of death, and

(II) an amount equal to the fair market value of the assets in such account on such date shall be includible if such person is not the estate of such holder, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such holder, in such holder's gross income for the last taxable year of such holder.

(ii) SPECIAL RULES.—

(I) REDUCTION OF INCLUSION FOR PRE-DEATH EXPENSES.—The amount includible in gross income under clause (i) by any person (other than the estate) shall be reduced by the amount of qualified medical expenses which were incurred by the de-

cedent before the date of the decedent's death and paid by such person within 1 year after such date.

(II) DEDUCTION FOR ESTATE TAXES.—An appropriate deduction shall be allowed under section 691(c) to any person (other than the decedent or the decedent's spouse) with respect to amounts included in gross income under clause (i) by such person.

(g) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 1998, each dollar amount in subsection (c)(2) shall be increased by an amount equal to—

(1) such dollar amount, multiplied by

(2) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting “calendar year 1997” for “calendar year 1992” in subparagraph (B) thereof.

If any increase under the preceding sentence is not a multiple of \$50, such increase shall be rounded to the nearest multiple of \$50.

(h) REPORTS.—The Secretary may require the trustee of an Archer MSA to make such reports regarding such account to the Secretary and to the account holder with respect to contributions, distributions, and such other matters as the Secretary determines appropriate. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.

(i) LIMITATION ON NUMBER OF TAXPAYERS HAVING ARCHER MSAS.—

(1) IN GENERAL.—Except as provided in paragraph (5), no individual shall be treated as an eligible individual for any taxable year beginning after the cut-off year unless—

(A) such individual was an active MSA participant for any taxable year ending on or before the close of the cut-off year, or

(B) such individual first became an active MSA participant for a taxable year ending after the cut-off year by reason of coverage under a high deductible health plan of an MSA-participating employer.

(2) CUT-OFF YEAR.—For purposes of paragraph (1), the term “cut-off year” means the earlier of—

(A) calendar year 2007, or

(B) the first calendar year before 2007 for which the Secretary determines under subsection (j) that the numerical limitation for such year has been exceeded.

(3) ACTIVE MSA PARTICIPANT.—For purposes of this subsection—

(A) IN GENERAL.—The term “active MSA participant” means, with respect to any taxable year, any individual who is the account holder of any Archer MSA into which any contribution was made which was excludable from gross income under section 106(b), or allowable as a deduction under this section, for such taxable year.

(B) SPECIAL RULE FOR CUT-OFF YEARS BEFORE 2007.—In the case of a cut-off year before 2007—

(i) an individual shall not be treated as an eligible individual for any month of such year or an active MSA participant under paragraph (1)(A) unless such individual is, on or before the cut-off date, covered under a high deductible health plan, and

(ii) an employer shall not be treated as an MSA-participating employer unless the employer, on or before the cut-off date, offered coverage under a high deductible health plan to any employee.

(C) CUT-OFF DATE.—For purposes of subparagraph (B)—

(i) IN GENERAL.—Except as otherwise provided in this subparagraph, the cut-off date is October 1 of the cut-off year.

(ii) EMPLOYEES WITH ENROLLMENT PERIODS AFTER OCTOBER 1.—In the case of an individual described in subclause (I) of subsection (c)(1)(A)(iii), if the regularly scheduled enrollment period for health plans of the individual's employer occurs during the last 3 months of the cut-off year, the cut-off date is December 31 of the cut-off year.

(iii) SELF-EMPLOYED INDIVIDUALS.—In the case of an individual described in subclause (II) of subsection (c)(1)(A)(iii), the cut-off date is November 1 of the cut-off year.

(iv) SPECIAL RULES FOR 1997.—If 1997 is a cut-off year by reason of subsection (j)(1)(A)—

(I) each of the cut-off dates under clauses (i) and (iii) shall be 1 month earlier than the date determined without regard to this clause, and

(II) clause (ii) shall be applied by substituting “4 months” for “3 months”.

(4) MSA-PARTICIPATING EMPLOYER.—For purposes of this subsection, the term “MSA-participating employer” means any small employer if—

(A) such employer made any contribution to the Archer MSA of any employee during the cut-off year or any preceding calendar year which was excludable from gross income under section 106(b), or

(B) at least 20 percent of the employees of such employer who are eligible individuals for any month of the cut-off year by reason of coverage under a high deductible health plan of such employer each made a contribution of at least \$100 to their Archer MSAs for any taxable year ending with or within the cut-off year which was allowable as a deduction under this section.

(5) ADDITIONAL ELIGIBILITY AFTER CUT-OFF YEAR.—If the Secretary determines under subsection (j)(2)(A) that the numerical limit for the calendar year following a cut-off year described in paragraph (2)(B) has not been exceeded—

(A) this subsection shall not apply to any otherwise eligible individual who is covered under a high deductible health plan during the first 6 months of the second calendar year following the cut-off year (and such individual shall be treated as an active MSA participant for purposes

of this subsection if a contribution is made to any Archer MSA with respect to such coverage), and

(B) any employer who offers coverage under a high deductible health plan to any employee during such 6-month period shall be treated as an MSA-participating employer for purposes of this subsection if the requirements of paragraph (4) are met with respect to such coverage.

For purposes of this paragraph, subsection (j)(2)(A) shall be applied for 1998 by substituting “750,000” for “600,000”.

(j) DETERMINATION OF WHETHER NUMERICAL LIMITS ARE EXCEEDED.—

(1) DETERMINATION OF WHETHER LIMIT EXCEEDED FOR 1997.—The numerical limitation for 1997 is exceeded if, based on the reports required under paragraph (4), the number of Archer MSAs established as of—

(A) April 30, 1997, exceeds 375,000, or

(B) June 30, 1997, exceeds 525,000.

(2) DETERMINATION OF WHETHER LIMIT EXCEEDED FOR 1998, 1999, 2001, 2002, 2004, 2005, OR 2006.—

(A) IN GENERAL.—The numerical limitation for 1998, 1999, 2001, 2002, 2004, 2005, or 2006 is exceeded if the sum of—

(i) the number of MSA returns filed on or before April 15 of such calendar year for taxable years ending with or within the preceding calendar year, plus

(ii) the Secretary’s estimate (determined on the basis of the returns described in clause (i)) of the number of MSA returns for such taxable years which will be filed after such date,

exceeds 750,000 (600,000 in the case of 1998). For purposes of the preceding sentence, the term “MSA return” means any return on which any exclusion is claimed under section 106(b) or any deduction is claimed under this section.

(B) ALTERNATIVE COMPUTATION OF LIMITATION.—The numerical limitation for 1998, 1999, 2001, 2002, 2004, 2005, or 2006 is also exceeded if the sum of—

(i) 90 percent of the sum determined under subparagraph (A) for such calendar year, plus

(ii) the product of 2.5 and the number of Archer MSAs established during the portion of such year preceding July 1 (based on the reports required under paragraph (4)) for taxable years beginning in such year,

exceeds 750,000.

(C) NO LIMITATION FOR 2000 OR 2003.—The numerical limitation shall not apply for 2000 or 2003.

(3) PREVIOUSLY UNINSURED INDIVIDUALS NOT INCLUDED IN DETERMINATION.—

(A) IN GENERAL.—The determination of whether any calendar year is a cut-off year shall be made by not counting the Archer MSA of any previously uninsured individual.

(B) PREVIOUSLY UNINSURED INDIVIDUAL.—For purposes of this subsection, the term “previously uninsured indi-

vidual” means, with respect to any Archer MSA, any individual who had no health plan coverage (other than coverage referred to in subsection (c)(1)(B)) at any time during the 6-month period before the date such individual’s coverage under the high deductible health plan commences.

(4) REPORTING BY MSA TRUSTEES.—

(A) IN GENERAL.—Not later than August 1 of 1997, 1998, 1999, 2001, 2002, 2004, 2005, and 2006, each person who is the trustee of an Archer MSA established before July 1 of such calendar year shall make a report to the Secretary (in such form and manner as the Secretary shall specify) which specifies—

(i) the number of Archer MSAs established before such July 1 (for taxable years beginning in such calendar year) of which such person is the trustee,

(ii) the name and TIN of the account holder of each such account, and

(iii) the number of such accounts which are accounts of previously uninsured individuals.

(B) ADDITIONAL REPORT FOR 1997.—Not later than June 1, 1997, each person who is the trustee of an Archer MSA established before May 1, 1997, shall make an additional report described in subparagraph (A) but only with respect to accounts established before May 1, 1997.

(C) PENALTY FOR FAILURE TO FILE REPORT.—The penalty provided in section 6693(a) shall apply to any report required by this paragraph, except that—

(i) such section shall be applied by substituting “\$25” for “\$50”, and

(ii) the maximum penalty imposed on any trustee shall not exceed \$5,000.

(D) AGGREGATION OF ACCOUNTS.—To the extent practicable, in determining the number of Archer MSAs on the basis of the reports under this paragraph, all Archer MSAs of an individual shall be treated as 1 account and all accounts of individuals who are married to each other shall be treated as 1 account.

(5) DATE OF MAKING DETERMINATIONS.—Any determination under this subsection that a calendar year is a cut-off year shall be made by the Secretary and shall be published not later than October 1 of such year.

* * * * *

SEC. 223. HEALTH SAVINGS ACCOUNTS.

(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by or on behalf of such individual to a health savings account of such individual.

(b) LIMITATIONS.—

(1) IN GENERAL.—The amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months dur-

ing such taxable year that the individual is an eligible individual.

(2) MONTHLY LIMITATION.—The monthly limitation for any month is $\frac{1}{12}$ of—

(A) in the case of an eligible individual who has self-only coverage under a high deductible health plan as of the first day of such month, **["\$2,250"]** *the amount in effect under subsection (c)(2)(A)(ii)(I).*

(B) in the case of an eligible individual who has family coverage under a high deductible health plan as of the first day of such month, **["\$4,500"]** *the amount in effect under subsection (c)(2)(A)(ii)(II).*

(3) ADDITIONAL CONTRIBUTIONS FOR INDIVIDUALS 55 OR OLDER.—

(A) IN GENERAL.—In the case of an individual who has attained age 55 before the close of the taxable year, the applicable limitation under subparagraphs (A) and (B) of paragraph (2) shall be increased by the additional contribution amount.

(B) ADDITIONAL CONTRIBUTION AMOUNT.—For purposes of this section, the additional contribution amount is the amount determined in accordance with the following table:

For taxable years beginning in:	The additional contribution amount is:
2004	\$500
2005	\$600
2006	\$700
2007	\$800
2008	\$900
2009 and thereafter	\$1,000.

(4) COORDINATION WITH OTHER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to an individual for any taxable year shall be reduced (but not below zero) by the sum of—

(A) the aggregate amount paid for such taxable year to Archer MSAs of such individual,

(B) the aggregate amount contributed to health savings accounts of such individual which is excludable from the taxpayer's gross income for such taxable year under section 106(d) (and such amount shall not be allowed as a deduction under subsection (a)), and

(C) the aggregate amount contributed to health savings accounts of such individual for such taxable year under section 408(d)(9) (and such amount shall not be allowed as a deduction under subsection (a)).

Subparagraph (A) shall not apply with respect to any individual to whom paragraph (5) applies.

[(5) SPECIAL RULE FOR MARRIED INDIVIDUALS.—In the case of individuals who are married to each other, if either spouse has family coverage—

[(A) both spouses shall be treated as having only such family coverage (and if such spouses each have family cov-

erage under different plans, as having the family coverage with the lowest annual deductible), and

[(B) the limitation under paragraph (1) (after the application of subparagraph (A) and without regard to any additional contribution amount under paragraph (3))—

[(i) shall be reduced by the aggregate amount paid to Archer MSAs of such spouses for the taxable year, and

[(ii) after such reduction, shall be divided equally between them unless they agree on a different division.]]

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

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

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

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

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

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

(6) *DENIAL OF DEDUCTION TO DEPENDENTS.*—*No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.*

(7) *MEDICARE ELIGIBLE INDIVIDUALS.*—*The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.*

(8) *INCREASE IN LIMIT FOR INDIVIDUALS BECOMING ELIGIBLE INDIVIDUALS AFTER THE BEGINNING OF THE YEAR.*—

(A) *IN GENERAL.*—*For purposes of computing the limitation under paragraph (1) for any taxable year, an indi-*

vidual who is an eligible individual during the last month of such taxable year shall be treated—

- (i) as having been an eligible individual during each of the months in such taxable year, and
- (ii) as having been enrolled, during each of the months such individual is treated as an eligible individual solely by reason of clause (i), in the same high deductible health plan in which the individual was enrolled for the last month of such taxable year.

(B) FAILURE TO MAINTAIN HIGH DEDUCTIBLE HEALTH PLAN COVERAGE.—

(i) IN GENERAL.—If, at any time during the testing period, the individual is not an eligible individual, then—

(I) gross income of the individual for the taxable year in which occurs the first month in the testing period for which such individual is not an eligible individual is increased by the aggregate amount of all contributions to the health savings account of the individual which could not have been made but for subparagraph (A), and

(II) the tax imposed by this chapter for any taxable year on the individual shall be increased by 10 percent of the amount of such increase.

(ii) EXCEPTION FOR DISABILITY OR DEATH.—Subclauses (I) and (II) of clause (i) shall not apply if the individual ceased to be an eligible individual by reason of the death of the individual or the individual becoming disabled (within the meaning of section 72(m)(7)).

(iii) TESTING PERIOD.—The term “testing period” means the period beginning with the last month of the taxable year referred to in subparagraph (A) and ending on the last day of the 12th month following such month.

(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

(1) ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—The term “eligible individual” means, with respect to any month, any individual if—

- (i) such individual is covered under a high deductible health plan as of the 1st day of such month, and
- (ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

(I) which is not a high deductible health plan, and

(II) which provides coverage for any benefit which is covered under the high deductible health plan.

(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A)(ii) shall be applied without regard to—

- (i) coverage for any benefit provided by permitted insurance,

(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care, and

(iii) for taxable years beginning after December 31, 2006, coverage under a health flexible spending arrangement during any period immediately following the end of a plan year of such arrangement during which unused benefits or contributions remaining at the end of such plan year may be paid or reimbursed to plan participants for qualified benefit expenses incurred during such period if—

(I) the balance in such arrangement at the end of such plan year is zero, or

(II) the individual is making a qualified HSA distribution (as defined in section 106(e)) in an amount equal to the remaining balance in such arrangement as of the end of such plan year, in accordance with rules prescribed by the Secretary.

(C) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR CERTAIN VETERANS BENEFITS.—An individual shall not fail to be treated as an eligible individual for any period merely because the individual receives hospital care or medical services under any law administered by the Secretary of Veterans Affairs for a service-connected disability (within the meaning of section 101(16) of title 38, United States Code).

(2) HIGH DEDUCTIBLE HEALTH PLAN.—

(A) IN GENERAL.—The term “high deductible health plan” means a health plan—

(i) which has an annual deductible which is not less than—

(I) \$1,000 for self-only coverage, and

(II) twice the dollar amount in subclause (I) for family coverage, and

(ii) the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—

(I) \$5,000 for self-only coverage, and

(II) twice the dollar amount in subclause (I) for family coverage.

(B) EXCLUSION OF CERTAIN PLANS.—Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B).

(C) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary).

(D) SPECIAL RULES FOR NETWORK PLANS.—In the case of a plan using a network of providers—

(i) ANNUAL OUT-OF-POCKET LIMITATION.—Such plan shall not fail to be treated as a high deductible health

plan by reason of having an out-of-pocket limitation for services provided outside of such network which exceeds the applicable limitation under subparagraph (A)(ii).

(ii) ANNUAL DEDUCTIBLE.—Such plan’s annual deductible for services provided outside of such network shall not be taken into account for purposes of subsection (b)(2).

(3) PERMITTED INSURANCE.—The term “permitted insurance” means—

(A) insurance if substantially all of the coverage provided under such insurance relates to—

(i) liabilities incurred under workers’ compensation laws,

(ii) tort liabilities,

(iii) liabilities relating to ownership or use of property, or

(iv) such other similar liabilities as the Secretary may specify by regulations,

(B) insurance for a specified disease or illness, and

(C) insurance paying a fixed amount per day (or other period) of hospitalization.

(4) FAMILY COVERAGE.—The term “family coverage” means any coverage other than self-only coverage.

(5) ARCHER MSA.—The term “Archer MSA” has the meaning given such term in section 220(d).

(d) HEALTH SAVINGS ACCOUNT.—For purposes of this section—

(1) IN GENERAL.—The term “health savings account” means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the following requirements:

(A) Except in the case of a rollover contribution described in subsection (f)(5) or section 220(f)(5), no contribution will be accepted—

(i) unless it is in cash, or

(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds the sum of—

(I) the dollar amount in effect under subsection (b)(2)(B), and

(II) the dollar amount in effect under subsection (b)(3)(B).

(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

(C) No part of the trust assets will be invested in life insurance contracts.

(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

(E) The interest of an individual in the balance in his account is nonforfeitable.

(2) QUALIFIED MEDICAL EXPENSES.—

(A) IN GENERAL.—The term “qualified medical expenses” means, with respect to an account beneficiary, amounts paid by such beneficiary for medical care (as defined in section 213(d) for such individual, the spouse of such individual, and any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise. [Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.]

(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Subparagraph (A) shall not apply to any payment for insurance.

(C) EXCEPTIONS.—Subparagraph (B) shall not apply to any expense for coverage under—

(i) a health plan during any period of continuation coverage required under any Federal law,

(ii) a qualified long-term care insurance contract (as defined in section 7702B(b)),

(iii) a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law, or

(iv) in the case of an account beneficiary who has attained the age specified in section 1811 of the Social Security Act, any health insurance other than a medicare supplemental policy (as defined in section 1882 of the Social Security Act).

(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.*

(3) ACCOUNT BENEFICIARY.—The term “account beneficiary” means the individual on whose behalf the health savings account was established.

(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

(A) Section 219(d)(2) (relating to no deduction for rollovers).

(B) Section 219(f)(3) (relating to time when contributions deemed made).

(C) Except as provided in section 106(d), section 219(f)(5) (relating to employer payments).

(D) Section 408(g) (relating to community property laws).

(E) Section 408(h) (relating to custodial accounts).

(e) TAX TREATMENT OF ACCOUNTS.—

(1) IN GENERAL.—A health savings account is exempt from taxation under this subtitle unless such account has ceased to be a health savings account. Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to health savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

(f) TAX TREATMENT OF DISTRIBUTIONS.—

(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a health savings account which is used exclusively to pay qualified medical expenses of any account beneficiary shall not be includible in gross income.

(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a health savings account which is not used exclusively to pay the qualified medical expenses of the account beneficiary shall be included in the gross income of such beneficiary.

(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—

(A) IN GENERAL.—If any excess contribution is contributed for a taxable year to any health savings account of an individual, paragraph (2) shall not apply to distributions from the health savings accounts of such individual (to the extent such distributions do not exceed the aggregate excess contributions to all such accounts of such individual for such year) if—

(i) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

(ii) such distribution is accompanied by the amount of net income attributable to such excess contribution. Any net income described in clause (ii) shall be included in the gross income of the individual for the taxable year in which it is received.

(B) EXCESS CONTRIBUTION.—For purposes of subparagraph (A), the term “excess contribution” means any contribution (other than a rollover contribution described in paragraph (5) or section 220(f)(5)) which is neither excludable from gross income under section 106(d) nor deductible under this section.

(4) ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

(A) IN GENERAL.—The tax imposed by this chapter on the account beneficiary for any taxable year in which there

is a payment or distribution from a health savings account of such beneficiary which is includible in gross income under paragraph (2) shall be increased by ~~20 percent~~ 10 percent of the amount which is so includible.

(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

(C) EXCEPTION FOR DISTRIBUTIONS AFTER MEDICARE ELIGIBILITY.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains the age specified in section 1811 of the Social Security Act.

(5) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a health savings account to the account beneficiary to the extent the amount received is paid into a health savings account for the benefit of such beneficiary not later than the 60th day after the day on which the beneficiary receives the payment or distribution.

(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a health savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a health savings account which was not includible in the individual's gross income because of the application of this paragraph.

(6) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of determining the amount of the deduction under section 213, any payment or distribution out of a health savings account for qualified medical expenses shall not be treated as an expense paid for medical care.

(7) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in a health savings account to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a health savings account with respect to which such spouse is the account beneficiary.

(8) TREATMENT AFTER DEATH OF ACCOUNT BENEFICIARY.—

(A) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—If the account beneficiary's surviving spouse acquires such beneficiary's interest in a health savings account by reason of being the designated beneficiary of such account at the death of the account beneficiary, such health savings account shall be treated as if the spouse were the account beneficiary.

(B) OTHER CASES.—

(i) IN GENERAL.—If, by reason of the death of the account beneficiary, any person acquires the account beneficiary's interest in a health savings account in a case to which subparagraph (A) does not apply—

(I) such account shall cease to be a health savings account as of the date of death, and

(II) an amount equal to the fair market value of the assets in such account on such date shall be includible if such person is not the estate of such beneficiary, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such beneficiary, in such beneficiary's gross income for the last taxable year of such beneficiary.

(ii) SPECIAL RULES.—

(I) REDUCTION OF INCLUSION FOR PREDEATH EXPENSES.—The amount includible in gross income under clause (i) by any person (other than the estate) shall be reduced by the amount of qualified medical expenses which were incurred by the decedent before the date of the decedent's death and paid by such person within 1 year after such date.

(II) DEDUCTION FOR ESTATE TAXES.—An appropriate deduction shall be allowed under section 691(c) to any person (other than the decedent or the decedent's spouse) with respect to amounts included in gross income under clause (i) by such person.

(g) COST-OF-LIVING ADJUSTMENT.—

(1) IN GENERAL.—Each dollar amount in [subsections (b)(2) and] *subsection (c)(2)(A)* shall be increased by an amount equal to—

(A) such dollar amount, multiplied by

(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins [determined by substituting for “calendar year 1992” in subparagraph (B) thereof—] *determined by substituting “calendar year 2003” for “calendar year 1992” in subparagraph (B) thereof.*

[(i) except as provided in clause (ii), “calendar year 1997”, and

[(ii) in the case of each dollar amount in subsection (c)(2)(A), “calendar year 2003”.]

In the case of adjustments made for any taxable year beginning after 2007, section 1(f)(4) shall be applied for purposes of this paragraph by substituting “March 31” for “August 31”, and the Secretary shall publish the adjusted amounts under [subsections (b)(2) and] *subsection (c)(2)(A)* for taxable years beginning in any calendar year no later than June 1 of the preceding calendar year.

(2) ROUNDING.—If any increase under paragraph (1) is not a multiple of \$50, such increase shall be rounded to the nearest multiple of \$50.

(h) REPORTS.—The Secretary may require—

(1) the trustee of a health savings account to make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, the return of excess contributions, and such other matters as the Secretary determines appropriate, and

(2) any person who provides an individual with a high deductible health plan to make such reports to the Secretary and to the account beneficiary with respect to such plan as the Secretary determines appropriate.

The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.

* * * * *

CHAPTER 2—TAX ON SELF-EMPLOYMENT INCOME

SEC. 1401. RATE OF TAX.

(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to 12.4 percent of the amount of the self-employment income for such taxable year.

[(b) HOSPITAL INSURANCE.—

[(1) IN GENERAL.—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.

[(2) ADDITIONAL TAX.—

[(A) IN GENERAL.—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) for each taxable year beginning after December 31, 2012, a tax equal to 0.9 percent of the self-employment income for such taxable year which is in excess of—

[(i) in the case of a joint return, \$250,000,

[(ii) in the case of a married taxpayer (as defined in section 7703) filing a separate return, ½ of the dollar amount determined under clause (i), and

[(iii) in any other case, \$200,000.

[(B) COORDINATION WITH FICA.—The amounts under clause (i), (ii), or (iii) (whichever is applicable) of subparagraph (A) shall be reduced (but not below zero) by the amount of wages taken into account in determining the tax imposed under section 3121(b)(2) with respect to the taxpayer.]

(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) **RELIEF FROM TAXES IN CASES COVERED BY CERTAIN INTERNATIONAL AGREEMENTS.**—During any period in which there is in effect an agreement entered into pursuant to section 233 of the Social Security Act with any foreign country, the self-employment income of an individual shall be exempt from the taxes imposed by this section to the extent that such self-employment income is subject under such agreement exclusively to the laws applicable to the social security system of such foreign country.

* * * * *

[CHAPTER 2A—UNEARNED INCOME MEDICARE CONTRIBUTION

[SEC. 1411. IMPOSITION OF TAX.

[(a) IN GENERAL.—Except as provided in subsection (e)—

[(1) APPLICATION TO INDIVIDUALS.—In the case of an individual, there is hereby imposed (in addition to any other tax imposed by this subtitle) for each taxable year a tax equal to 3.8 percent of the lesser of—

[(A) net investment income for such taxable year, or

[(B) the excess (if any) of—

[(i) the modified adjusted gross income for such taxable year, over

[(ii) the threshold amount.

[(2) APPLICATION TO ESTATES AND TRUSTS.—In the case of an estate or trust, there is hereby imposed (in addition to any other tax imposed by this subtitle) for each taxable year a tax of 3.8 percent of the lesser of—

[(A) the undistributed net investment income for such taxable year, or

[(B) the excess (if any) of—

[(i) the adjusted gross income (as defined in section 67(e)) for such taxable year, over

[(ii) the dollar amount at which the highest tax bracket in section 1(e) begins for such taxable year.

[(b) THRESHOLD AMOUNT.—For purposes of this chapter, the term “threshold amount” means—

[(1) in the case of a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), \$250,000,

[(2) in the case of a married taxpayer (as defined in section 7703) filing a separate return, ½ of the dollar amount determined under paragraph (1), and

[(3) in any other case, \$200,000.

[(c) NET INVESTMENT INCOME.—For purposes of this chapter—

[(1) IN GENERAL.—The term “net investment income” means the excess (if any) of—

[(A) the sum of—

[(i) gross income from interest, dividends, annuities, royalties, and rents, other than such income which is derived in the ordinary course of a trade or business not described in paragraph (2),

[(ii) other gross income derived from a trade or business described in paragraph (2), and

[(iii) net gain (to the extent taken into account in computing taxable income) attributable to the disposition of property other than property held in a trade or business not described in paragraph (2), over (B) the deductions allowed by this subtitle which are properly allocable to such gross income or net gain.

[(2) TRADES AND BUSINESSES TO WHICH TAX APPLIES.—A trade or business is described in this paragraph if such trade or business is—

[(A) a passive activity (within the meaning of section 469) with respect to the taxpayer, or

[(B) a trade or business of trading in financial instruments or commodities (as defined in section 475(e)(2)).

[(3) INCOME ON INVESTMENT OF WORKING CAPITAL SUBJECT TO TAX.—A rule similar to the rule of section 469(e)(1)(B) shall apply for purposes of this subsection.

[(4) EXCEPTION FOR CERTAIN ACTIVE INTERESTS IN PARTNERSHIPS AND S CORPORATIONS.—In the case of a disposition of an interest in a partnership or S corporation—

[(A) gain from such disposition shall be taken into account under clause (iii) of paragraph (1)(A) only to the extent of the net gain which would be so taken into account by the transferor if all property of the partnership or S corporation were sold for fair market value immediately before the disposition of such interest, and

[(B) a rule similar to the rule of subparagraph (A) shall apply to a loss from such disposition.

[(5) EXCEPTION FOR DISTRIBUTIONS FROM QUALIFIED PLANS.—The term “net investment income” shall not include any distribution from a plan or arrangement described in section 401(a), 403(a), 403(b), 408, 408A, or 457(b).

[(6) SPECIAL RULE.—Net investment income shall not include any item taken into account in determining self-employment income for such taxable year on which a tax is imposed by section 1401(b).

[(d) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this chapter, the term “modified adjusted gross income” means adjusted gross income increased by the excess of—

[(1) the amount excluded from gross income under section 911(a)(1), over

[(2) the amount of any deductions (taken into account in computing adjusted gross income) or exclusions disallowed under section 911(d)(6) with respect to the amounts described in paragraph (1).

[(e) NONAPPLICATION OF SECTION.—This section shall not apply to—

[(1) a nonresident alien, or

[(2) a trust all of the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).]

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Subtitle C—Employment Taxes

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CHAPTER 21—FEDERAL INSURANCE CONTRIBUTIONS ACT

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Subchapter A—Tax on Employees

SEC. 3101. RATE OF TAX.

(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to 6.2 percent of the wages (as defined in section 3121(a)) received by the individual with respect to employment (as defined in section 3121(b)).

[(b) HOSPITAL INSURANCE.—

[(1) IN GENERAL.—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 him with respect to employment (as defined in section 3121(b)).

[(2) ADDITIONAL TAX.—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) a tax equal to 0.9 percent of wages which are received with respect to employment (as defined in section 3121(b)) during any taxable year beginning after December 31, 2012, and which are in excess of—

[(A) in the case of a joint return, \$250,000,

[(B) in the case of a married taxpayer (as defined in section 7703) filing a separate return, ½ of the dollar amount determined under subparagraph (A), and

[(C) in any other case, \$200,000.]

(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)).*

(c) RELIEF FROM TAXES IN CASES COVERED BY CERTAIN INTERNATIONAL AGREEMENTS.—During any period in which there is in effect an agreement entered into pursuant to section 233 of the Social Security Act with any foreign country, wages received by or paid to an individual shall be exempt from the taxes imposed by this section to the extent that such wages are subject under such agreement exclusively to the laws applicable to the social security system of such foreign country.

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Subtitle D—Miscellaneous Excise Taxes

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CHAPTER 32—MANUFACTURERS EXCISE TAXES

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Subchapter E—Medical Devices

SEC. 4191. MEDICAL DEVICES.

(a) **IN GENERAL.**—There is hereby imposed on the sale of any taxable medical device by the manufacturer, producer, or importer a tax equal to 2.3 percent of the price for which so sold.

(b) **TAXABLE MEDICAL DEVICE.**—For purposes of this section—

(1) **IN GENERAL.**—The term “taxable medical device” means any device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) intended for humans.

(2) **EXEMPTIONS.**—Such term shall not include—

(A) eyeglasses,

(B) contact lenses,

(C) hearing aids, and

(D) any other medical device determined by the Secretary to be of a type which is generally purchased by the general public at retail for individual use.

(c) **MORATORIUM.**—The tax imposed under subsection (a) shall not apply to sales during the period beginning on January 1, 2016, and ending on December 31, 2017.

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

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CHAPTER 43—QUALIFIED PENSION, ETC., PLANS

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SEC. 4980H. SHARED RESPONSIBILITY FOR EMPLOYERS REGARDING HEALTH COVERAGE.

(a) **LARGE EMPLOYERS NOT OFFERING HEALTH COVERAGE.**—If—

(1) any applicable large employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

(2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

(b) LARGE EMPLOYERS OFFERING COVERAGE WITH EMPLOYEES WHO QUALIFY FOR PREMIUM TAX CREDITS OR COST-SHARING REDUCTIONS.—

(1) IN GENERAL.—If—

(A) an applicable large employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

(B) 1 or more full-time employees of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and an amount equal to $\frac{1}{12}$ of \$3,000 (*\$0 in the case of months beginning after December 31, 2015*).

(2) OVERALL LIMITATION.—The aggregate amount of tax determined under paragraph (1) with respect to all employees of an applicable large employer for any month shall not exceed the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

(1) APPLICABLE PAYMENT AMOUNT.—The term “applicable payment amount” means, with respect to any month, $\frac{1}{12}$ of \$2,000 (*\$0 in the case of months beginning after December 31, 2015*).

(2) APPLICABLE LARGE EMPLOYER.—

(A) IN GENERAL.—The term “applicable large employer” means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.

(B) EXEMPTION FOR CERTAIN EMPLOYERS.—

(i) IN GENERAL.—An employer shall not be considered to employ more than 50 full-time employees if—

(I) the employer’s workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year, and

(II) the employees in excess of 50 employed during such 120-day period were seasonal workers.

(ii) DEFINITION OF SEASONAL WORKERS.—The term “seasonal worker” means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section

500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

(C) RULES FOR DETERMINING EMPLOYER SIZE.—For purposes of this paragraph—

(i) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(ii) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is an applicable large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(iii) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(D) APPLICATION OF EMPLOYER SIZE TO ASSESSABLE PENALTIES.—

(i) IN GENERAL.—The number of individuals employed by an applicable large employer as full-time employees during any month shall be reduced by 30 solely for purposes of calculating—

(I) the assessable payment under subsection (a),

or

(II) the overall limitation under subsection (b)(2).

(ii) AGGREGATION.—In the case of persons treated as 1 employer under subparagraph (C)(i), only 1 reduction under subclause (I) or (II) shall be allowed with respect to such persons and such reduction shall be allocated among such persons ratably on the basis of the number of full-time employees employed by each such person.

(E) FULL-TIME EQUIVALENTS TREATED AS FULL-TIME EMPLOYEES.—Solely for purposes of determining whether an employer is an applicable large employer under this paragraph, an employer shall, in addition to the number of full-time employees for any month otherwise determined, include for such month a number of full-time employees determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

(F) EXEMPTION FOR HEALTH COVERAGE UNDER TRICARE OR THE VETERANS ADMINISTRATION.—Solely for purposes of determining whether an employer is an applicable large employer under this paragraph for any month, an individual shall not be taken into account as an employee for such month if such individual has medical coverage for such month under—

(i) chapter 55 of title 10, United States Code, including coverage under the TRICARE program, or

(ii) 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.

(3) **APPLICABLE PREMIUM TAX CREDIT AND COST-SHARING REDUCTION.**—The term “applicable premium tax credit and cost-sharing reduction” means—

(A) any premium tax credit allowed under section 36B,

(B) any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act, and

(C) any advance payment of such credit or reduction under section 1412 of such Act.

(4) **FULL-TIME EMPLOYEE.**—

(A) **IN GENERAL.**—The term “full-time employee” means, with respect to any month, an employee who is employed on average at least 30 hours of service per week.

(B) **HOURS OF SERVICE.**—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

(5) **INFLATION ADJUSTMENT.**—

(A) **IN GENERAL.**—In the case of any calendar year after 2014, each of the dollar amounts in subsection (b) and paragraph (1) shall be increased by an amount equal to the product of—

(i) such dollar amount, and

(ii) the premium adjustment percentage (as defined in section 1302(c)(4) of the Patient Protection and Affordable Care Act) for the calendar year.

(B) **ROUNDING.**—If the amount of any increase under subparagraph (A) is not a multiple of \$10, such increase shall be rounded to the next lowest multiple of \$10.

(6) **OTHER DEFINITIONS.**—Any term used in this section which is also used in the Patient Protection and Affordable Care Act shall have the same meaning as when used in such Act.

(7) **TAX NONDEDUCTIBLE.**—For denial of deduction for the tax imposed by this section, see section 275(a)(6).

(d) **ADMINISTRATION AND PROCEDURE.**—

(1) **IN GENERAL.**—Any assessable payment provided by this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) **TIME FOR PAYMENT.**—The Secretary may provide for the payment of any assessable payment provided by this section on an annual, monthly, or other periodic basis as the Secretary may prescribe.

(3) **COORDINATION WITH CREDITS, ETC.**—The Secretary shall prescribe rules, regulations, or guidance for the repayment of

any assessable payment (including interest) if such payment is based on the allowance or payment of an applicable premium tax credit or cost-sharing reduction with respect to an employee, such allowance or payment is subsequently disallowed, and the assessable payment would not have been required to be made but for such allowance or payment.

SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) IMPOSITION OF TAX.—If—

(1) an employee is covered under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and

(2) there is any excess benefit with respect to the coverage, there is hereby imposed a tax equal to 40 percent of the excess benefit.

(b) EXCESS BENEFIT.—For purposes of this section—

(1) IN GENERAL.—The term “excess benefit” means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined under paragraph (2) for months during the taxable period.

(2) MONTHLY EXCESS AMOUNT.—The excess amount determined under this paragraph for any month is the excess (if any) of—

(A) the aggregate cost of the applicable employer-sponsored coverage of the employee for the month, over

(B) an amount equal to $\frac{1}{12}$ of the annual limitation under paragraph (3) for the calendar year in which the month occurs.

(3) ANNUAL LIMITATION.—For purposes of this subsection—

(A) IN GENERAL.—The annual limitation under this paragraph for any calendar year is the dollar limit determined under subparagraph (C) for the calendar year.

(B) APPLICABLE ANNUAL LIMITATION.—

(i) IN GENERAL.—Except as provided in clause (ii), the annual limitation which applies for any month shall be determined on the basis of the type of coverage (as determined under subsection (f)(1)) provided to the employee by the employer as of the beginning of the month.

(ii) MULTIEMPLOYER PLAN COVERAGE.—Any coverage provided under a multiemployer plan (as defined in section 414(f)) shall be treated as coverage other than self-only coverage.

(C) APPLICABLE DOLLAR LIMIT.—

(i) 2018.—In the case of 2018, the dollar limit under this subparagraph is—

(I) in the case of an employee with self-only coverage, \$10,200 multiplied by the health cost adjustment percentage (determined by only taking into account self-only coverage), and

(II) in the case of an employee with coverage other than self-only coverage, \$27,500 multiplied by the health cost adjustment percentage (deter-

mined by only taking into account coverage other than self-only coverage).

(ii) HEALTH COST ADJUSTMENT PERCENTAGE.—For purposes of clause (i), the health cost adjustment percentage is equal to 100 percent plus the excess (if any) of—

(I) the percentage by which the per employee cost for providing coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010, over

(II) 55 percent.

(iii) AGE AND GENDER ADJUSTMENT.—

(I) IN GENERAL.—The amount determined under subclause (I) or (II) of clause (i), whichever is applicable, for any taxable period shall be increased by the amount determined under subclause (II).

(II) AMOUNT DETERMINED.—The amount determined under this subclause is an amount equal to the excess (if any) of—

(aa) the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for the type of coverage provided such individual in such taxable period if priced for the age and gender characteristics of all employees of the individual's employer, over

(bb) that premium cost for the provision of such coverage under such option in such taxable period if priced for the age and gender characteristics of the national workforce.

(iv) EXCEPTION FOR CERTAIN INDIVIDUALS.—In the case of an individual who is a qualified retiree or who participates in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical or telecommunications lines—

(I) the dollar amount in clause (i)(I) shall be increased by \$1,650, and

(II) the dollar amount in clause (i)(II) shall be increased by \$3,450,

(v) SUBSEQUENT YEARS.—In the case of any calendar year after 2018, each of the dollar amounts under clauses (i) (after the application of clause (ii)) and (iv) shall be increased to the amount equal to such amount as determined for the calendar year preceding such year, increased by an amount equal to the product of—

(I) such amount as so determined, multiplied by

(II) the cost-of-living adjustment determined under section 1(f)(3) for such year (determined by substituting the calendar year that is 2 years before such year for “1992” in subparagraph (B)

thereof), increased by 1 percentage point in the case of determinations for calendar years beginning before 2020.

If any amount determined under this clause is not a multiple of \$50, such amount shall be rounded to the nearest multiple of \$50.

(c) LIABILITY TO PAY TAX.—

(1) IN GENERAL.—Each coverage provider shall pay the tax imposed by subsection (a) on its applicable share of the excess benefit with respect to an employee for any taxable period.

(2) COVERAGE PROVIDER.—For purposes of this subsection, the term “coverage provider” means each of the following:

(A) HEALTH INSURANCE COVERAGE.—If the applicable employer-sponsored coverage consists of coverage under a group health plan which provides health insurance coverage, the health insurance issuer.

(B) HSA AND MSA CONTRIBUTIONS.—If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the employer.

(C) OTHER COVERAGE.—In the case of any other applicable employer-sponsored coverage, the person that administers the plan benefits.

(3) APPLICABLE SHARE.—For purposes of this subsection, a coverage provider’s applicable share of an excess benefit for any taxable period is the amount which bears the same ratio to the amount of such excess benefit as—

(A) the cost of the applicable employer-sponsored coverage provided by the provider to the employee during such period, bears to

(B) the aggregate cost of all applicable employer-sponsored coverage provided to the employee by all coverage providers during such period.

(4) RESPONSIBILITY TO CALCULATE TAX AND APPLICABLE SHARES.—

(A) IN GENERAL.—Each employer shall—

(i) calculate for each taxable period the amount of the excess benefit subject to the tax imposed by subsection (a) and the applicable share of such excess benefit for each coverage provider, and

(ii) notify, at such time and in such manner as the Secretary may prescribe, the Secretary and each coverage provider of the amount so determined for the provider.

(B) SPECIAL RULE FOR MULTIEMPLOYER PLANS.—In the case of applicable employer-sponsored coverage made available to employees through a multiemployer plan (as defined in section 414(f)), the plan sponsor shall make the calculations, and provide the notice, required under subparagraph (A).

(d) APPLICABLE EMPLOYER-SPONSORED COVERAGE; COST.—For purposes of this section—

(1) APPLICABLE EMPLOYER-SPONSORED COVERAGE.—

(A) IN GENERAL.—The term “applicable employer-sponsored coverage” means, with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee’s gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).

(B) EXCEPTIONS.—The term “applicable employer-sponsored coverage” shall not include—

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

(ii) 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, or

(iii) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

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

(D) SELF-EMPLOYED INDIVIDUAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(l) with respect to all or any portion of the cost of the coverage.

(E) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

(2) DETERMINATION OF COST.—

(A) IN GENERAL.—The cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4), except that in determining such cost, any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account and the amount of such cost shall be calculated separately for self-only coverage and other coverage. In the case of applicable employer-sponsored 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 applicable employer-sponsored coverage consisting of coverage under a flexible

spending arrangement (as defined in section 106(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 reimbursement under the arrangement in excess of the contributions described in clause (i).

(C) ARCHER MSAS AND HSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

(D) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—In the case of applicable employer-sponsored 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).

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

(3) EMPLOYEE.—The term “employee” includes any former employee, surviving spouse, or other primary insured individual.

(e) PENALTY FOR FAILURE TO PROPERLY CALCULATE EXCESS BENEFIT.—

(1) IN GENERAL.—If, for any taxable period, the tax imposed by subsection (a) exceeds the tax determined under such subsection with respect to the total excess benefit calculated by the employer or plan sponsor under subsection (c)(4)—

(A) each coverage provider shall pay the tax on its applicable share (determined in the same manner as under subsection (c)(4)) of the excess, but no penalty shall be imposed on the provider with respect to such amount, and

(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a), pay a penalty in an amount equal to such excess, plus interest at the underpayment rate determined under section 6621 for the period beginning on the due date for the payment of tax imposed by subsection (a) to which the excess relates and ending on the date of payment of the penalty.

(2) LIMITATIONS ON PENALTY.—

(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by paragraph (1)(B) on any failure to properly calculate the excess benefit during any period for which it is established to the satisfaction of the Secretary that the employer or plan sponsor neither knew, nor exercising reasonable diligence would have known, that such failure existed.

(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be imposed by paragraph (1)(B) on any such failure if—

(i) such failure was due to reasonable cause and not to willful neglect, and

(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

(C) WAIVER BY SECRETARY.—In the case of any such failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by paragraph (1), to the extent that the payment of such penalty would be excessive or otherwise inequitable relative to the failure involved.

(f) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

(1) COVERAGE DETERMINATIONS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an employee shall be treated as having self-only coverage with respect to any applicable employer-sponsored coverage of an employer.

(B) MINIMUM ESSENTIAL COVERAGE.—An employee shall be treated as having coverage other than self-only coverage only if the employee is enrolled in coverage other than self-only coverage in a group health plan which provides minimum essential coverage (as defined in section 5000A(f)) to the employee and at least one other beneficiary, and the benefits provided under such minimum essential coverage do not vary based on whether any individual covered under such coverage is the employee or another beneficiary.

(2) QUALIFIED RETIREE.—The term “qualified retiree” means any individual who—

(A) is receiving coverage by reason of being a retiree,

(B) has attained age 55, and

(C) is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act.

(3) EMPLOYEES ENGAGED IN HIGH-RISK PROFESSION.—The term “employees engaged in a high-risk profession” means law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), individuals whose primary work is longshore work (as defined in section 258(b) of the Immigration and Nationality Act (8 U.S.C. 1288(b)), determined without regard to paragraph (2) thereof), and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an employee who is retired from a high-risk profession described in

the preceding sentence, if such employee satisfied the requirements of such sentence for a period of not less than 20 years during the employee's employment.

(4) **GROUP HEALTH PLAN.**—The term “group health plan” has the meaning given such term by section 5000(b)(1). Section 9831(d)(1) shall not apply for purposes of this section.

(5) **HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.**—

(A) **HEALTH INSURANCE COVERAGE.**—The term “health insurance coverage” has the meaning given such term by section 9832(b)(1) (applied without regard to subparagraph (B) thereof, except as provided by the Secretary in regulations).

(B) **HEALTH INSURANCE ISSUER.**—The term “health insurance issuer” has the meaning given such term by section 9832(b)(2).

(6) **PERSON THAT ADMINISTERS THE PLAN BENEFITS.**—The term “person that administers the plan benefits” shall include the plan sponsor if the plan sponsor administers benefits under the plan.

(7) **PLAN SPONSOR.**—The term “plan sponsor” has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(8) **TAXABLE PERIOD.**—The term “taxable period” means the calendar year or such shorter period as the Secretary may prescribe. The Secretary may have different taxable periods for employers of varying sizes.

(9) **AGGREGATION RULES.**—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.

(10) **DEDUCTIBILITY OF TAX.**—Section 275(a)(6) shall not apply to the tax imposed by subsection (a).

(g) **REGULATIONS.**—The Secretary shall prescribe such regulations as may be necessary to carry out this section.

(h) **SHALL NOT APPLY.**—*No tax shall be imposed under this section with respect to any taxable period beginning after December 31, 2019, and before January 1, 2025.*

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CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) **REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.**—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) **SHARED RESPONSIBILITY PAYMENT.**—

(1) **IN GENERAL.**—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of

subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) INCLUSION WITH RETURN.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) PAYMENT OF PENALTY.—If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) AMOUNT OF PENALTY.—

(1) IN GENERAL.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) MONTHLY PENALTY AMOUNTS.—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to $\frac{1}{12}$ of the greater of the following amounts:

(A) FLAT DOLLAR AMOUNT.—An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) PERCENTAGE OF INCOME.—An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) **[2.5 percent]** *Zero percent* for taxable years beginning after 2015.

(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is **[\$695]** \$0.

(B) PHASE IN.—The applicable dollar amount is \$95 for 2014 and \$325 for 2015.

(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

[(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to \$695, increased by an amount equal to—

[(i) \$695, multiplied by

[(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting “calendar year 2015” for “calendar year 1992” in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.]

(4) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

(A) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) HOUSEHOLD INCOME.—The term “household income” means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer’s family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) MODIFIED ADJUSTED GROSS INCOME.—The term “modified adjusted gross income” means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911, and

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

(1) IN GENERAL.—The term “applicable individual” means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) RELIGIOUS EXEMPTIONS.—

(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

(B) HEALTH CARE SHARING MINISTRY.—

(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) HEALTH CARE SHARING MINISTRY.—The term “health care sharing ministry” means an organization—

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

(II) 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,

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

(IV) 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

(V) 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.

(3) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) INCARCERATED INDIVIDUALS.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) EXEMPTIONS.—No penalty shall be imposed under subsection (a) with respect to—

(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

(A) IN GENERAL.—Any applicable individual for any month if the applicable individual’s required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual’s household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer’s house-

hold income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) REQUIRED CONTRIBUTION.—For purposes of this paragraph, the term “required contribution” means—

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to required contribution of the employee.

(D) INDEXING.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for “8 percent” the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) TAXPAYERS WITH INCOME BELOW FILING THRESHOLD.—Any applicable individual for any month during a calendar year if the individual’s household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(3) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) MONTHS DURING SHORT COVERAGE GAPS.—

(A) IN GENERAL.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) SPECIAL RULES.—For purposes of applying this paragraph—

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) **HARDSHIPS.**—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) **MINIMUM ESSENTIAL COVERAGE.**—For purposes of this section—

(1) **IN GENERAL.**—The term “minimum essential coverage” means any of the following:

(A) **GOVERNMENT SPONSORED PROGRAMS.**—Coverage under—

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act,

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

(v) 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,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

(vii) 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).

(B) **EMPLOYER-SPONSORED PLAN.**—Coverage under an eligible employer-sponsored plan.

(C) **PLANS IN THE INDIVIDUAL MARKET.**—Coverage under a health plan offered in the individual market within a State.

(D) **GRANDFATHERED HEALTH PLAN.**—Coverage under a grandfathered health plan.

(E) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term “eligible employer-sponsored plan” means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term “minimum essential coverage” shall not include health insurance coverage which consists of coverage of excepted benefits—

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) ADMINISTRATION AND PROCEDURE.—

(1) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) SPECIAL RULES.—Notwithstanding any other provision of law—

(A) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) LIMITATIONS ON LIENS AND LEVIES.—The Secretary shall not—

- (i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or
- (ii) levy on any such property with respect to such failure.

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[CHAPTER 49—COSMETIC SERVICES

[SEC. 5000B. IMPOSITION OF TAX ON INDOOR TANNING SERVICES.

[(a) IN GENERAL.—There is hereby imposed on any indoor tanning service a tax equal to 10 percent of the amount paid for such service (determined without regard to this section), whether paid by insurance or otherwise.

[(b) INDOOR TANNING SERVICE.—For purposes of this section—

[(1) IN GENERAL.—The term “indoor tanning service” means a service employing any electronic product designed to incorporate 1 or more ultraviolet lamps and intended for the irradiation of an individual by ultraviolet radiation, with wavelengths in air between 200 and 400 nanometers, to induce skin tanning.

[(2) EXCLUSION OF PHOTOTHERAPY SERVICES.—Such term does not include any phototherapy service performed by a licensed medical professional.

[(c) PAYMENT OF TAX.—

[(1) IN GENERAL.—The tax imposed by this section shall be paid by the individual on whom the service is performed.

[(2) COLLECTION.—Every person receiving a payment for services on which a tax is imposed under subsection (a) shall collect the amount of the tax from the individual on whom the service is performed and remit such tax quarterly to the Secretary at such time and in such manner as provided by the Secretary.

[(3) SECONDARY LIABILITY.—Where any tax imposed by subsection (a) is not paid at the time payments for indoor tanning services are made, then to the extent that such tax is not collected, such tax shall be paid by the person who performs the service.]

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Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter A—Returns and Records

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PART III—INFORMATION RETURNS

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Subpart B—Information Concerning Transactions with Other Persons

Sec. 6041. Information at source.

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Sec. 6050X. *Returns by health insurance providers relating to health insurance coverage credit.*

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SEC. 6050X. RETURNS BY HEALTH INSURANCE PROVIDERS 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 reporting under subsection (b) shall 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,

(E) whether such policy constitutes a high deductible health plan (as defined in section 223(c)(2)), and

(F) 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.

Subpart C—Information Regarding Wages Paid Employees

SEC. 6051. RECEIPTS FOR EMPLOYEES.

(a) REQUIREMENT.—Every person required to deduct and withhold from an employee a tax under section 3101 or 3402, or who would have been required to deduct and withhold a tax under section 3402 (determined without regard to subsection (n)) if the employee had claimed no more than one withholding exemption, or every employer engaged in a trade or business who pays remuneration for services performed by an employee, including the cash value of such remuneration paid in any medium other than cash, shall furnish to each such employee in respect of the remuneration paid by such person to such employee during the calendar year, on or before January 31 of the succeeding year, or, if his employment is terminated before the close of such calendar year, within 30 days after the date of receipt of a written request from the employee if such 30-day period ends before January 31, a written statement showing the following:

- (1) the name of such person,
- (2) the name of the employee (and an identifying number for the employee if wages as defined in section 3121(a) have been paid),
- (3) the total amount of wages as defined in section 3401(a),
- (4) the total amount deducted and withheld as tax under section 3402,
- (5) the total amount of wages as defined in section 3121(a),
- (6) the total amount deducted and withheld as tax under section 3101,
- (8) the total amount of elective deferrals (within the meaning of section 402(g)(3)) and compensation deferred under section 457, including the amount of designated Roth contributions (as defined in section 402A),
- (9) the total amount incurred for dependent care assistance with respect to such employee under a dependent care assistance program described in section 129(d),
- (10) in the case of an employee who is a member of the Armed Forces of the United States, such employee's earned income as determined for purposes of section 32 (relating to earned income credit),
- (11) the amount contributed to any Archer MSA (as defined in section 220(d)) of such employee or such employee's spouse,
- (12) the amount contributed to any health savings account (as defined in section 223(d)) of such employee or such employee's spouse,
- (13) the total amount of deferrals for the year under a non-qualified deferred compensation plan (within the meaning of section 409A(d)),
- (14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in section 4980I(d)(1)), except that this paragraph shall not apply to—

(A) coverage to which paragraphs (11) and (12) apply, or

(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125), **[and]**

(15) the total amount of permitted benefit (as defined in section 9831(d)(3)(C)) for the year under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2)) with respect to the employee**[.]**, and

(16) *each month with respect to which the employee is eligible for other specified coverage (as defined in section 36C(g)) in connection with employment with the employer.*

In the case of compensation paid for service as a member of a uniformed service, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(2). In the case of compensation paid for service as a volunteer or volunteer leader within the meaning of the Peace Corps Act, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(3). In the case of tips received by an employee in the course of his employment, the amounts required to be shown by paragraphs (3) and (5) shall include only such tips as are included in statements furnished to the employer pursuant to section 6053(a). The amounts required to be shown by paragraph (5) shall not include wages which are exempted pursuant to sections 3101(c) and 3111(c) from the taxes imposed by sections 3101 and 3111. In the case of the amounts required to be shown by paragraph (13), the Secretary may (by regulation) establish a minimum amount of deferrals below which paragraph (13) does not apply.

(b) SPECIAL RULE AS TO COMPENSATION OF MEMBERS OF ARMED FORCES.—In the case of compensation paid for service as a member of the Armed Forces, the statement required by subsection (a) shall be furnished if any tax was withheld during the calendar year under section 3402, or if any of the compensation paid during such year is includible in gross income under chapter 1, or if during the calendar year any amount was required to be withheld as tax under section 3101. In lieu of the amount required to be shown by paragraph (3) of subsection (a), such statement shall show as wages paid during the calendar year the amount of such compensation paid during the calendar year which is not excluded from gross income under chapter 1 (whether or not such compensation constituted wages as defined in section 3401(a)).

(c) ADDITIONAL REQUIREMENTS.—The statements required to be furnished pursuant to this section in respect of any remuneration shall be furnished at such other times, shall contain such other information, and shall be in such form as the Secretary may by regulations prescribe. The statements required under this section shall also show the proportion of the total amount withheld as tax under section 3101 which is for financing the cost of hospital insurance benefits under part A of title XVIII of the Social Security Act.

(d) STATEMENTS TO CONSTITUTE INFORMATION RETURNS.—A duplicate of any statement made pursuant to this section and in ac-

cordance with regulations prescribed by the Secretary shall, when required by such regulations, be filed with the Secretary.

(e) RAILROAD EMPLOYEES.—

(1) ADDITIONAL REQUIREMENT.—Every person required to deduct and withhold tax under section 3201 from an employee shall include on or with the statement required to be furnished such employee under subsection (a) a notice concerning the provisions of this title with respect to the allowance of a credit or refund of the tax on wages imposed by section 3101(b) and the tax on compensation imposed by section 3201 or 3211 which is treated as a tax on wages imposed by section 3101(b).

(2) INFORMATION TO BE SUPPLIED TO EMPLOYEES.—Each person required to deduct and withhold tax under section 3201 during any year from an employee who has also received wages during such year subject to the tax imposed by section 3101(b) shall, upon request of such employee, furnish to him a written statement showing—

(A) the total amount of compensation with respect to which the tax imposed by section 3201 was deducted,

(B) the total amount deducted as tax under section 3201, and

(C) the portion of the total amount deducted as tax under section 3201 which is for financing the cost of hospital insurance under part A of title XVIII of the Social Security Act.

(f) STATEMENTS REQUIRED IN CASE OF SICK PAY PAID BY THIRD PARTIES.—

(1) STATEMENTS REQUIRED FROM PAYOR.—

(A) IN GENERAL.—If, during any calendar year, any person makes a payment of third-party sick pay to an employee, such person shall, on or before January 15 of the succeeding year, furnish a written statement to the employer in respect of whom such payment was made showing—

(i) the name and, if there is withholding under section 3402(o), the social security number of such employee,

(ii) the total amount of the third-party sick pay paid to such employee during the calendar year, and

(iii) the total amount (if any) deducted and withheld from such sick pay under section 3402.

For purposes of the preceding sentence, the term “third-party sick pay” means any sick pay (as defined in section 3402(o)(2)(C)) which does not constitute wages for purposes of chapter 24 (determined without regard to section 3402(o)(1)).

(B) SPECIAL RULES.—

(i) STATEMENTS ARE IN LIEU OF OTHER REPORTING REQUIREMENTS.—The reporting requirements of subparagraph (A) with respect to any payments shall, with respect to such payments, be in lieu of the requirements of subsection (a) and of section 6041.

(ii) PENALTIES MADE APPLICABLE.—For purposes of sections 6674 and 7204, the statements required to be

furnished by subparagraph (A) shall be treated as statements required under this section to be furnished to employees.

(2) INFORMATION REQUIRED TO BE FURNISHED BY EMPLOYER.—Every employer who receives a statement under paragraph (1)(A) with respect to sick pay paid to any employee during any calendar year shall, on or before January 31 of the succeeding year, furnish a written statement to such employee showing—

(A) the information shown on the statement furnished under paragraph (1)(A), and

(B) if any portion of the sick pay is excludable from gross income under section 104(a)(3), the portion which is not so excludable and the portion which is so excludable.

To the extent practicable, the information required under the preceding sentence shall be furnished on or with the statement (if any) required under subsection (a).

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Subpart D—Information Regarding Health Insurance Coverage

SEC. 6055. REPORTING OF HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Every person who provides minimum essential coverage to an individual during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).

(b) FORM AND MANNER OF RETURN.—

(1) IN GENERAL.—A return is described in this subsection if such return—

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

(B) contains—

(i) the name, address and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy,

(ii) the dates during which such individual was covered under minimum essential coverage during the calendar year,

(iii) in the case of minimum essential coverage which consists of health insurance coverage, information concerning—

(I) whether or not the coverage is a qualified health plan offered through an Exchange established under section 1311 of the Patient Protection and Affordable Care Act, and

(II) in the case of a qualified health plan, the amount (if any) of any advance payment under section 1412 of the Patient Protection and Affordable Care Act of any cost-sharing reduction under section 1402 of such Act or of any premium tax credit under section 36B with respect to such coverage, and

(iv) such other information as the Secretary may require.

(2) INFORMATION RELATING TO EMPLOYER-PROVIDED COVERAGE.—If minimum essential coverage provided to an individual under subsection (a) consists of health insurance coverage of a health insurance issuer provided through a group health plan of an employer, a return described in this subsection shall include—

(A) the name, address, and employer identification number of the employer maintaining the plan,

(B) the portion of the premium (if any) required to be paid by the employer, and

(C) if the health insurance coverage is a qualified health plan in the small group market offered through an Exchange, such other information as the Secretary may require for administration of the credit under section 45R (relating to credit for employee health insurance expenses of small employers).

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

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

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

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

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

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

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

(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

(1) IN GENERAL.—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—

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

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

(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

(d) 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 make the returns and statements required by this section.

(e) **MINIMUM ESSENTIAL COVERAGE.**—For purposes of this section, the term “minimum essential coverage” has the meaning given such term by section 5000A(f).

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Subchapter B—Miscellaneous Provisions

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SEC. 6103. CONFIDENTIALITY AND DISCLOSURE OF RETURNS AND RETURN INFORMATION.

(a) **GENERAL RULE.**—Returns and return information shall be confidential, and except as authorized by this title—

(1) no officer or employee of the United States,

(2) no officer or employee of any State, any local law enforcement agency receiving information under subsection (i)(1)(C) or (7)(A), any local child support enforcement agency, or any local agency administering a program listed in subsection (l)(7)(D) who has or had access to returns or return information under this section or section 6104(c), and

(3) no other person (or officer or employee thereof) who has or had access to returns or return information under subsection (e)(1)(D)(iii), subsection (k)(10), paragraph (6), (10), (12), (16), (19), (20), or (21) of subsection (l), paragraph (2) or (4)(B) of subsection (m), or subsection (n),

shall disclose any return or return information obtained by him in any manner in connection with his service as such an officer or an employee or otherwise or under the provisions of this section. For purposes of this subsection, the term “officer or employee” includes a former officer or employee.

(b) **DEFINITIONS.**—For purposes of this section—

(1) **RETURN.**—The term “return” means any tax or information return, declaration of estimated tax, or claim for refund required by, or provided for or permitted under, the provisions of this title which is filed with the Secretary by, on behalf of, or with respect to any person, and any amendment or supplement thereto, including supporting schedules, attachments, or lists which are supplemental to, or part of, the return so filed.

(2) **RETURN INFORMATION.**—The term “return information” means—

(A) a taxpayer’s identity, the nature, source, or amount of his income, payments, receipts, deductions, exemptions, credits, assets, liabilities, net worth, tax liability, tax withheld, deficiencies, overassessments, or tax payments, whether the taxpayer’s return was, is being, or will be examined or subject to other investigation or processing, or any other data, received by, recorded by, prepared by, furnished to, or collected by the Secretary with respect to a return or with respect to the determination of the existence, or possible existence, of liability (or the amount

thereof) of any person under this title for any tax, penalty, interest, fine, forfeiture, or other imposition, or offense,

(B) any part of any written determination or any background file document relating to such written determination (as such terms are defined in section 6110(b)) which is not open to public inspection under section 6110,

(C) any advance pricing agreement entered into by a taxpayer and the Secretary and any background information related to such agreement or any application for an advance pricing agreement, and

(D) any agreement under section 7121, and any similar agreement, and any background information related to such an agreement or request for such an agreement,

but such term does not include data in a form which cannot be associated with, or otherwise identify, directly or indirectly, a particular taxpayer. Nothing in the preceding sentence, or in any other provision of law, shall be construed to require the disclosure of standards used or to be used for the selection of returns for examination, or data used or to be used for determining such standards, if the Secretary determines that such disclosure will seriously impair assessment, collection, or enforcement under the internal revenue laws.

(3) **TAXPAYER RETURN INFORMATION.**—The term “taxpayer return information” means return information as defined in paragraph (2) which is filed with, or furnished to, the Secretary by or on behalf of the taxpayer to whom such return information relates.

(4) **TAX ADMINISTRATION.**—The term “tax administration”—

(A) means—

(i) the administration, management, conduct, direction, and supervision of the execution and application of the internal revenue laws or related statutes (or equivalent laws and statutes of a State) and tax conventions to which the United States is a party, and

(ii) the development and formulation of Federal tax policy relating to existing or proposed internal revenue laws, related statutes, and tax conventions, and

(B) includes assessment, collection, enforcement, litigation, publication, and statistical gathering functions under such laws, statutes, or conventions.

(5) **STATE.**—

(A) **IN GENERAL.**—The term “State” means—

(i) any of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands,

(ii) for purposes of subsections (a)(2), (b)(4), (d)(1), (h)(4), and (p), any municipality—

(I) with a population in excess of 250,000 (as determined under the most recent decennial United States census data available),

(II) which imposes a tax on income or wages, and

(III) with which the Secretary (in his sole discretion) has entered into an agreement regarding disclosure, and

(iii) for purposes of subsections (a)(2), (b)(4), (d)(1), (h)(4), and (p), any governmental entity—

(I) which is formed and operated by a qualified group of municipalities, and

(II) with which the Secretary (in his sole discretion) has entered into an agreement regarding disclosure.

(B) REGIONAL INCOME TAX AGENCIES.—For purposes of subparagraph (A)(iii)—

(i) QUALIFIED GROUP OF MUNICIPALITIES.—The term “qualified group of municipalities” means, with respect to any governmental entity, 2 or more municipalities—

(I) each of which imposes a tax on income or wages,

(II) each of which, under the authority of a State statute, administers the laws relating to the imposition of such taxes through such entity, and

(III) which collectively have a population in excess of 250,000 (as determined under the most recent decennial United States census data available).

(ii) REFERENCES TO STATE LAW, ETC.—For purposes of applying subparagraph (A)(iii) to the subsections referred to in such subparagraph, any reference in such subsections to State law, proceedings, or tax returns shall be treated as references to the law, proceedings, or tax returns, as the case may be, of the municipalities which form and operate the governmental entity referred to in such subparagraph.

(iii) DISCLOSURE TO CONTRACTORS AND OTHER AGENTS.—Notwithstanding any other provision of this section, no return or return information shall be disclosed to any contractor or other agent of a governmental entity referred to in subparagraph (A)(iii) unless such entity, to the satisfaction of the Secretary—

(I) has requirements in effect which require each such contractor or other agent which would have access to returns or return information to provide safeguards (within the meaning of subsection (p)(4)) to protect the confidentiality of such returns or return information,

(II) agrees to conduct an on-site review every 3 years (or a mid-point review in the case of contracts or agreements of less than 3 years in duration) of each contractor or other agent to determine compliance with such requirements,

(III) submits the findings of the most recent review conducted under subclause (II) to the Secretary as part of the report required by subsection (p)(4)(E), and

(IV) certifies to the Secretary for the most recent annual period that such contractor or other agent is in compliance with all such requirements. The certification required by subclause (IV) shall include the name and address of each contractor and other agent, a description of the contract or agreement with such contractor or other agent, and the duration of such contract or agreement. The requirements of this clause shall not apply to disclosures pursuant to subsection (n) for purposes of Federal tax administration and a rule similar to the rule of subsection (p)(8)(B) shall apply for purposes of this clause.

(6) TAXPAYER IDENTITY.—The term “taxpayer identity” means the name of a person with respect to whom a return is filed, his mailing address, his taxpayer identifying number (as described in section 6109), or a combination thereof.

(7) INSPECTION.—The terms “inspected” and “inspection” mean any examination of a return or return information.

(8) DISCLOSURE.—The term “disclosure” means the making known to any person in any manner whatever a return or return information.

(9) FEDERAL AGENCY.—The term “Federal agency” means an agency within the meaning of section 551(1) of title 5, United States Code.

(10) CHIEF EXECUTIVE OFFICER.—The term “chief executive officer” means, with respect to any municipality, any elected official and the chief official (even if not elected) of such municipality.

(11) TERRORIST INCIDENT, THREAT, OR ACTIVITY.—The term “terrorist incident, threat, or activity” means an incident, threat, or activity involving an act of domestic terrorism (as defined in section 2331(5) of title 18, United States Code) or international terrorism (as defined in section 2331(1) of such title).

(c) DISCLOSURE OF RETURNS AND RETURN INFORMATION TO DESIGNEE OF TAXPAYER.—The Secretary may, subject to such requirements and conditions as he may prescribe by regulations, disclose the return of any taxpayer, or return information with respect to such taxpayer, to such person or persons as the taxpayer may designate in a request for or consent to such disclosure, or to any other person at the taxpayer’s request to the extent necessary to comply with a request for information or assistance made by the taxpayer to such other person. However, return information shall not be disclosed to such person or persons if the Secretary determines that such disclosure would seriously impair Federal tax administration.

(d) DISCLOSURE TO STATE TAX OFFICIALS AND STATE AND LOCAL LAW ENFORCEMENT AGENCIES.—

(1) IN GENERAL.—Returns and return information with respect to taxes imposed by chapters 1, 2, 6, 11, 12, 21, 23, 24, 31, 32, 44, 51, and 52 and subchapter D of chapter 36 shall be open to inspection by, or disclosure to, any State agency, body, or commission, or its legal representative, which is charged under the laws of such State with responsibility for the administration of State tax laws for the purpose of, and only to the

extent necessary in, the administration of such laws, including any procedures with respect to locating any person who may be entitled to a refund. Such inspection shall be permitted, or such disclosure made, only upon written request by the head of such agency, body, or commission, and only to the representatives of such agency, body, or commission designated in such written request as the individuals who are to inspect or to receive the returns or return information on behalf of such agency, body, or commission. Such representatives shall not include any individual who is the chief executive officer of such State or who is neither an employee or legal representative of such agency, body, or commission nor a person described in subsection (n). However, such return information shall not be disclosed to the extent that the Secretary determines that such disclosure would identify a confidential informant or seriously impair any civil or criminal tax investigation.

(2) DISCLOSURE TO STATE AUDIT AGENCIES.—

(A) IN GENERAL.—Any returns or return information obtained under paragraph (1) by any State agency, body, or commission may be open to inspection by, or disclosure to, officers and employees of the State audit agency for the purpose of, and only to the extent necessary in, making an audit of the State agency, body, or commission referred to in paragraph (1).

(B) STATE AUDIT AGENCY.—For purposes of subparagraph (A), the term “State audit agency” means any State agency, body, or commission which is charged under the laws of the State with the responsibility of auditing State revenues and programs.

(3) EXCEPTION FOR REIMBURSEMENT UNDER SECTION 7624.—Nothing in this section shall be construed to prevent the Secretary from disclosing to any State or local law enforcement agency which may receive a payment under section 7624 the amount of the recovered taxes with respect to which such a payment may be made.

(4) AVAILABILITY AND USE OF DEATH INFORMATION.—

(A) IN GENERAL.—No returns or return information may be disclosed under paragraph (1) to any agency, body, or commission of any State (or any legal representative thereof) during any period during which a contract meeting the requirements of subparagraph (B) is not in effect between such State and the Secretary of Health and Human Services.

(B) CONTRACTUAL REQUIREMENTS.—A contract meets the requirements of this subparagraph if—

(i) such contract requires the State to furnish the Secretary of Health and Human Services information concerning individuals with respect to whom death certificates (or equivalent documents maintained by the State or any subdivision thereof) have been officially filed with it, and

(ii) such contract does not include any restriction on the use of information obtained by such Secretary pursuant to such contract, except that such contract may

provide that such information is only to be used by the Secretary (or any other Federal agency) for purposes of ensuring that Federal benefits or other payments are not erroneously paid to deceased individuals.

Any information obtained by the Secretary of Health and Human Services under such a contract shall be exempt from disclosure under section 552 of title 5, United States Code, and from the requirements of section 552a of such title 5.

(C) SPECIAL EXCEPTION.—The provisions of subparagraph (A) shall not apply to any State which on July 1, 1993, was not, pursuant to a contract, furnishing the Secretary of Health and Human Services information concerning individuals with respect to whom death certificates (or equivalent documents maintained by the State or any subdivision thereof) have been officially filed with it.

(5) DISCLOSURE FOR COMBINED EMPLOYMENT TAX REPORTING.—

(A) IN GENERAL.—The Secretary may disclose taxpayer identity information and signatures to any agency, body, or commission of any State for the purpose of carrying out with such agency, body, or commission a combined Federal and State employment tax reporting program approved by the Secretary. Subsections (a)(2) and (p)(4) and sections 7213 and 7213A shall not apply with respect to disclosures or inspections made pursuant to this paragraph.

(B) TERMINATION.—The Secretary may not make any disclosure under this paragraph after December 31, 2007.

(6) LIMITATION ON DISCLOSURE REGARDING REGIONAL INCOME TAX AGENCIES TREATED AS STATES.—For purposes of paragraph (1), inspection by or disclosure to an entity described in subsection (b)(5)(A)(iii) shall be for the purpose of, and only to the extent necessary in, the administration of the laws of the member municipalities in such entity relating to the imposition of a tax on income or wages. Such entity may not redisclose any return or return information received pursuant to paragraph (1) to any such member municipality.

(e) DISCLOSURE TO PERSONS HAVING MATERIAL INTEREST.—

(1) IN GENERAL.—The return of a person shall, upon written request, be open to inspection by or disclosure to—

(A) in the case of the return of an individual—

- (i) that individual,
- (ii) the spouse of that individual if the individual and such spouse have signified their consent to consider a gift reported on such return as made one-half by him and one-half by the spouse pursuant to the provisions of section 2513; or
- (iii) the child of that individual (or such child's legal representative) to the extent necessary to comply with the provisions of section 1(g);

(B) in the case of an income tax return filed jointly, either of the individuals with respect to whom the return is filed;

(C) in the case of the return of a partnership, any person who was a member of such partnership during any part of the period covered by the return;

(D) in the case of the return of a corporation or a subsidiary thereof—

(i) any person designated by resolution of its board of directors or other similar governing body,

(ii) any officer or employee of such corporation upon written request signed by any principal officer and attested to by the secretary or other officer,

(iii) any bona fide shareholder of record owning 1 percent or more of the outstanding stock of such corporation,

(iv) if the corporation was an S corporation, any person who was a shareholder during any part of the period covered by such return during which an election under section 1362(a) was in effect, or

(v) if the corporation has been dissolved, any person authorized by applicable State law to act for the corporation or any person who the Secretary finds to have a material interest which will be affected by information contained therein;

(E) in the case of the return of an estate—

(i) the administrator, executor, or trustee of such estate, and

(ii) any heir at law, next of kin, or beneficiary under the will, of the decedent, but only if the Secretary finds that such heir at law, next of kin, or beneficiary has a material interest which will be affected by information contained therein; and

(F) in the case of the return of a trust—

(i) the trustee or trustees, jointly or separately, and

(ii) any beneficiary of such trust, but only if the Secretary finds that such beneficiary has a material interest which will be affected by information contained therein.

(2) INCOMPETENCY.—If an individual described in paragraph (1) is legally incompetent, the applicable return shall, upon written request, be open to inspection by or disclosure to the committee, trustee, or guardian of his estate.

(3) DECEASED INDIVIDUALS.—The return of a decedent shall, upon written request, be open to inspection by or disclosure to—

(A) the administrator, executor, or trustee of his estate, and

(B) any heir at law, next of kin, or beneficiary under the will, of such decedent, or a donee of property, but only if the Secretary finds that such heir at law, next of kin, beneficiary, or donee has a material interest which will be affected by information contained therein.

(4) TITLE 11 CASES AND RECEIVERSHIP PROCEEDINGS.—If—

(A) there is a trustee in a title 11 case in which the debtor is the person with respect to whom the return is filed, or

(B) substantially all of the property of the person with respect to whom the return is filed is in the hands of a receiver,

such return or returns for prior years of such person shall, upon written request, be open to inspection by or disclosure to such trustee or receiver, but only if the Secretary finds that such trustee or receiver, in his fiduciary capacity, has a material interest which will be affected by information contained therein.

(5) INDIVIDUAL'S TITLE 11 CASE.—

(A) IN GENERAL.—In any case to which section 1398 applies (determined without regard to section 1398(b)(1)), any return of the debtor for the taxable year in which the case commenced or any preceding taxable year shall, upon written request, be open to inspection by or disclosure to the trustee in such case.

(B) RETURN OF ESTATE AVAILABLE TO DEBTOR.—Any return of an estate in a case to which section 1398 applies shall, upon written request, be open to inspection by or disclosure to the debtor in such case.

(C) SPECIAL RULE FOR INVOLUNTARY CASES.—In an involuntary case, no disclosure shall be made under subparagraph (A) until the order for relief has been entered by the court having jurisdiction of such case unless such court finds that such disclosure is appropriate for purposes of determining whether an order for relief should be entered.

(6) ATTORNEY IN FACT.—Any return to which this subsection applies shall, upon written request, also be open to inspection by or disclosure to the attorney in fact duly authorized in writing by any of the persons described in paragraph (1), (2), (3), (4), (5), (8), or (9) to inspect the return or receive the information on his behalf, subject to the conditions provided in such paragraphs.

(7) RETURN INFORMATION.—Return information with respect to any taxpayer may be open to inspection by or disclosure to any person authorized by this subsection to inspect any return of such taxpayer if the Secretary determines that such disclosure would not seriously impair Federal tax administration.

(8) DISCLOSURE OF COLLECTION ACTIVITIES WITH RESPECT TO JOINT RETURN.—If any deficiency of tax with respect to a joint return is assessed and the individuals filing such return are no longer married or no longer reside in the same household, upon request in writing by either of such individuals, the Secretary shall disclose in writing to the individual making the request whether the Secretary has attempted to collect such deficiency from such other individual, the general nature of such collection activities, and the amount collected. The preceding sentence shall not apply to any deficiency which may not be collected by reason of section 6502.

(9) DISCLOSURE OF CERTAIN INFORMATION WHERE MORE THAN 1 PERSON SUBJECT TO PENALTY UNDER SECTION 6672.—If the Secretary determines that a person is liable for a penalty under section 6672(a) with respect to any failure, upon request

in writing of such person, the Secretary shall disclose in writing to such person—

(A) the name of any other person whom the Secretary has determined to be liable for such penalty with respect to such failure, and

(B) whether the Secretary has attempted to collect such penalty from such other person, the general nature of such collection activities, and the amount collected.

(10) LIMITATION ON CERTAIN DISCLOSURES UNDER THIS SUBSECTION.—In the case of an inspection or disclosure under this subsection relating to the return of a partnership, S corporation, trust, or an estate, the information inspected or disclosed shall not include any supporting schedule, attachment, or list which includes the taxpayer identity information of a person other than the entity making the return or the person conducting the inspection or to whom the disclosure is made.

(11) DISCLOSURE OF INFORMATION REGARDING STATUS OF INVESTIGATION OF VIOLATION OF THIS SECTION.—In the case of a person who provides to the Secretary information indicating a violation of section 7213, 7213A, or 7214 with respect to any return or return information of such person, the Secretary may disclose to such person (or such person's designee)—

(A) whether an investigation based on the person's provision of such information has been initiated and whether it is open or closed,

(B) whether any such investigation substantiated such a violation by any individual, and

(C) whether any action has been taken with respect to such individual (including whether a referral has been made for prosecution of such individual).

(f) DISCLOSURE TO COMMITTEES OF CONGRESS.—

(1) COMMITTEE ON WAYS AND MEANS, COMMITTEE ON FINANCE, AND JOINT COMMITTEE ON TAXATION.—Upon written request from the chairman of the Committee on Ways and Means of the House of Representatives, the chairman of the Committee on Finance of the Senate, or the chairman of the Joint Committee on Taxation, the Secretary shall furnish such committee with any return or return information specified in such request, except that any return or return information which can be associated with, or otherwise identify, directly or indirectly, a particular taxpayer shall be furnished to such committee only when sitting in closed executive session unless such taxpayer otherwise consents in writing to such disclosure.

(2) CHIEF OF STAFF OF JOINT COMMITTEE ON TAXATION.—Upon written request by the Chief of Staff of the Joint Committee on Taxation, the Secretary shall furnish him with any return or return information specified in such request. Such Chief of Staff may submit such return or return information to any committee described in paragraph (1), except that any return or return information which can be associated with, or otherwise identify, directly or indirectly, a particular taxpayer shall be furnished to such committee only when sitting in closed executive session unless such taxpayer otherwise consents in writing to such disclosure.

(3) OTHER COMMITTEES.—Pursuant to an action by, and upon written request by the chairman of, a committee of the Senate or the House of Representatives (other than a committee specified in paragraph (1)) specially authorized to inspect any return or return information by a resolution of the Senate or the House of Representatives or, in the case of a joint committee (other than the joint committee specified in paragraph (1)) by concurrent resolution, the Secretary shall furnish such committee, or a duly authorized and designated subcommittee thereof, sitting in closed executive session, with any return or return information which such resolution authorizes the committee or subcommittee to inspect. Any resolution described in this paragraph shall specify the purpose for which the return or return information is to be furnished and that such information cannot reasonably be obtained from any other source.

(4) AGENTS OF COMMITTEES AND SUBMISSION OF INFORMATION TO SENATE OR HOUSE OF REPRESENTATIVES.—

(A) COMMITTEES DESCRIBED IN PARAGRAPH (1).—Any committee described in paragraph (1) or the Chief of Staff of the Joint Committee on Taxation shall have the authority, acting directly, or by or through such examiners or agents as the chairman of such committee or such chief of staff may designate or appoint, to inspect returns and return information at such time and in such manner as may be determined by such chairman or chief of staff. Any return or return information obtained by or on behalf of such committee pursuant to the provisions of this subsection may be submitted by the committee to the Senate or the House of Representatives, or to both. The Joint Committee on Taxation may also submit such return or return information to any other committee described in paragraph (1), except that any return or return information which can be associated with, or otherwise identify, directly or indirectly, a particular taxpayer shall be furnished to such committee only when sitting in closed executive session unless such taxpayer otherwise consents in writing to such disclosure.

(B) OTHER COMMITTEES.—Any committee or subcommittee described in paragraph (3) shall have the right, acting directly, or by or through no more than four examiners or agents, designated or appointed in writing in equal numbers by the chairman and ranking minority member of such committee or subcommittee, to inspect returns and return information at such time and in such manner as may be determined by such chairman and ranking minority member. Any return or return information obtained by or on behalf of such committee or subcommittee pursuant to the provisions of this subsection may be submitted by the committee to the Senate or the House of Representatives, or to both, except that any return or return information which can be associated with, or otherwise identify, directly or indirectly, a particular taxpayer, shall be furnished to the Senate or the House of Representatives only when sitting in closed executive session unless such taxpayer otherwise consents in writing to such disclosure.

(5) DISCLOSURE BY WHISTLEBLOWER.—Any person who otherwise has or had access to any return or return information under this section may disclose such return or return information to a committee referred to in paragraph (1) or any individual authorized to receive or inspect information under paragraph (4)(A) if such person believes such return or return information may relate to possible misconduct, maladministration, or taxpayer abuse.

(g) DISCLOSURE TO PRESIDENT AND CERTAIN OTHER PERSONS.—

(1) IN GENERAL.—Upon written request by the President, signed by him personally, the Secretary shall furnish to the President, or to such employee or employees of the White House Office as the President may designate by name in such request, a return or return information with respect to any taxpayer named in such request. Any such request shall state—

(A) the name and address of the taxpayer whose return or return information is to be disclosed,

(B) the kind of return or return information which is to be disclosed,

(C) the taxable period or periods covered by such return or return information, and

(D) the specific reason why the inspection or disclosure is requested.

(2) DISCLOSURE OF RETURN INFORMATION AS TO PRESIDENTIAL APPOINTEES AND CERTAIN OTHER FEDERAL GOVERNMENT APPOINTEES.—The Secretary may disclose to a duly authorized representative of the Executive Office of the President or to the head of any Federal agency, upon written request by the President or head of such agency, or to the Federal Bureau of Investigation on behalf of and upon written request by the President or such head, return information with respect to an individual who is designated as being under consideration for appointment to a position in the executive or judicial branch

of the Federal Government. Such return information shall be limited to whether such individual—

(A) has filed returns with respect to the taxes imposed under chapter 1 for not more than the immediately preceding 3 years;

(B) has failed to pay any tax within 10 days after notice and demand, or has been assessed any penalty under this title for negligence, in the current year or immediately preceding 3 years;

(C) has been or is under investigation for possible criminal offenses under the internal revenue laws and the results of any such investigation; or

(D) has been assessed any civil penalty under this title for fraud.

Within 3 days of the receipt of any request for any return information with respect to any individual under this paragraph, the Secretary shall notify such individual in writing that such information has been requested under the provisions of this paragraph.

(3) RESTRICTION ON DISCLOSURE.—The employees to whom returns and return information are disclosed under this subsection shall not disclose such returns and return information to any other person except the President or the head of such agency without the personal written direction of the President or the head of such agency.

(4) RESTRICTION ON DISCLOSURE TO CERTAIN EMPLOYEES.—Disclosure of returns and return information under this subsection shall not be made to any employee whose annual rate of basic pay is less than the annual rate of basic pay specified for positions subject to section 5316 of title 5, United States Code.

(5) REPORTING REQUIREMENTS.—Within 30 days after the close of each calendar quarter, the President and the head of any agency requesting returns and return information under this subsection shall each file a report with the Joint Committee on Taxation setting forth the taxpayers with respect to whom such requests were made during such quarter under this subsection, the returns or return information involved, and the reasons for such requests. The President shall not be required to report on any request for returns and return information pertaining to an individual who was an officer or employee of the executive branch of the Federal Government at the time such request was made. Reports filed pursuant to this paragraph shall not be disclosed unless the Joint Committee on Taxation determines that disclosure thereof (including identifying details) would be in the national interest. Such reports shall be maintained by the Joint Committee on Taxation for a period not exceeding 2 years unless, within such period, the Joint Committee on Taxation determines that a disclosure to the Congress is necessary.

(h) DISCLOSURE TO CERTAIN FEDERAL OFFICERS AND EMPLOYEES FOR PURPOSES OF TAX ADMINISTRATION, ETC.—

(1) DEPARTMENT OF THE TREASURY.—Returns and return information shall, without written request, be open to inspection

by or disclosure to officers and employees of the Department of the Treasury whose official duties require such inspection or disclosure for tax administration purposes.

(2) DEPARTMENT OF JUSTICE.—In a matter involving tax administration, a return or return information shall be open to inspection by or disclosure to officers and employees of the Department of Justice (including United States attorneys) personally and directly engaged in, and solely for their use in, any proceeding before a Federal grand jury or preparation for any proceeding (or investigation which may result in such a proceeding) before a Federal grand jury or any Federal or State court, but only if—

(A) the taxpayer is or may be a party to the proceeding, or the proceeding arose out of, or in connection with, determining the taxpayer's civil or criminal liability, or the collection of such civil liability in respect of any tax imposed under this title;

(B) the treatment of an item reflected on such return is or may be related to the resolution of an issue in the proceeding or investigation; or

(C) such return or return information relates or may relate to a transactional relationship between a person who is or may be a party to the proceeding and the taxpayer which affects, or may affect, the resolution of an issue in such proceeding or investigation.

(3) FORM OF REQUEST.—In any case in which the Secretary is authorized to disclose a return or return information to the Department of Justice pursuant to the provisions of this subsection—

(A) if the Secretary has referred the case to the Department of Justice, or if the proceeding is authorized by subchapter B of chapter 76, the Secretary may make such disclosure on his own motion, or

(B) if the Secretary receives a written request from the Attorney General, the Deputy Attorney General, or an Assistant Attorney General for a return of, or return information relating to, a person named in such request and setting forth the need for the disclosure, the Secretary shall disclose return or return the information so requested.

(4) DISCLOSURE IN JUDICIAL AND ADMINISTRATIVE TAX PROCEEDINGS.—A return or return information may be disclosed in a Federal or State judicial or administrative proceeding pertaining to tax administration, but only—

(A) if the taxpayer is a party to the proceeding, or the proceeding arose out of, or in connection with, determining the taxpayer's civil or criminal liability, or the collection of such civil liability, in respect of any tax imposed under this title;

(B) if the treatment of an item reflected on such return is directly related to the resolution of an issue in the proceeding;

(C) if such return or return information directly relates to a transactional relationship between a person who is a

party to the proceeding and the taxpayer which directly affects the resolution of an issue in the proceeding; or

(D) to the extent required by order of a court pursuant to section 3500 of title 18, United States Code, or rule 16 of the Federal Rules of Criminal Procedure, such court being authorized in the issuance of such order to give due consideration to congressional policy favoring the confidentiality of returns and return information as set forth in this title.

However, such return or return information shall not be disclosed as provided in subparagraph (A), (B), or (C) if the Secretary determines that such disclosure would identify a confidential informant or seriously impair a civil or criminal tax investigation.

(5) WITHHOLDING OF TAX FROM SOCIAL SECURITY BENEFITS.—

Upon written request of the payor agency, the Secretary may disclose available return information from the master files of the Internal Revenue Service with respect to the address and status of an individual as a nonresident alien or as a citizen or resident of the United States to the Social Security Administration or the Railroad Retirement Board (whichever is appropriate) for purposes of carrying out its responsibilities for withholding tax under section 1441 from social security benefits (as defined in section 86(d)).

(6) INTERNAL REVENUE SERVICE OVERSIGHT BOARD.—

(A) IN GENERAL.—Notwithstanding paragraph (1), and except as provided in subparagraph (B), no return or return information may be disclosed to any member of the Oversight Board described in subparagraph (A) or (D) of section 7802(b)(1) or to any employee or detailee of such Board by reason of their service with the Board. Any request for information not permitted to be disclosed under the preceding sentence, and any contact relating to a specific taxpayer, made by any such individual to an officer or employee of the Internal Revenue Service shall be reported by such officer or employee to the Secretary, the Treasury Inspector General for Tax Administration, and the Joint Committee on Taxation.

(B) EXCEPTION FOR REPORTS TO THE BOARD.—If—

(i) the Commissioner or the Treasury Inspector General for Tax Administration prepares any report or other matter for the Oversight Board in order to assist the Board in carrying out its duties; and

(ii) the Commissioner or such Inspector General determines it is necessary to include any return or return information in such report or other matter to enable the Board to carry out such duties, such return or return information (other than information regarding taxpayer identity) may be disclosed to members, employees, or detailees of the Board solely for the purpose of carrying out such duties.

(i) DISCLOSURE TO FEDERAL OFFICERS OR EMPLOYEES FOR ADMINISTRATION OF FEDERAL LAWS NOT RELATING TO TAX ADMINISTRATION.—

(1) DISCLOSURE OF RETURNS AND RETURN INFORMATION FOR USE IN CRIMINAL INVESTIGATIONS.—

(A) IN GENERAL.—Except as provided in paragraph (6), any return or return information with respect to any specified taxable period or periods shall, pursuant to and upon the grant of an ex parte order by a Federal district court judge or magistrate judge under subparagraph (B), be open (but only to the extent necessary as provided in such order) to inspection by, or disclosure to, officers and employees of any Federal agency who are personally and directly engaged in—

(i) preparation for any judicial or administrative proceeding pertaining to the enforcement of a specifically designated Federal criminal statute (not involving tax administration) to which the United States or such agency is or may be a party, or pertaining to the case of a missing or exploited child,

(ii) any investigation which may result in such a proceeding, or

(iii) any Federal grand jury proceeding pertaining to enforcement of such a criminal statute to which the United States or such agency is or may be a party, or to such a case of a missing or exploited child,

solely for the use of such officers and employees in such preparation, investigation, or grand jury proceeding.

(B) APPLICATION FOR ORDER.—The Attorney General, the Deputy Attorney General, the Associate Attorney General, any Assistant Attorney General, any United States attorney, any special prosecutor appointed under section 593 of title 28, United States Code, or any attorney in charge of a criminal division organized crime strike force established pursuant to section 510 of title 28, United States Code, may authorize an application to a Federal district court judge or magistrate judge for the order referred to in subparagraph (A). Upon such application, such judge or magistrate judge may grant such order if he determines on the basis of the facts submitted by the applicant that—

(i) there is reasonable cause to believe, based upon information believed to be reliable, that a specific criminal act has been committed,

(ii) there is reasonable cause to believe that the return or return information is or may be relevant to a matter relating to the commission of such act, and

(iii) the return or return information is sought exclusively for use in a Federal criminal investigation or proceeding concerning such act (or any criminal investigation or proceeding, in the case of a matter relating to a missing or exploited child), and the information sought to be disclosed cannot reasonably be obtained, under the circumstances, from another source.

(C) DISCLOSURE TO STATE AND LOCAL LAW ENFORCEMENT AGENCIES IN THE CASE OF MATTERS PERTAINING TO A MISSING OR EXPLOITED CHILD.—

(i) IN GENERAL.—In the case of an investigation pertaining to a missing or exploited child, the head of any Federal agency, or his designee, may disclose any return or return information obtained under subparagraph (A) to officers and employees of any State or local law enforcement agency, but only if—

(I) such State or local law enforcement agency is part of a team with the Federal agency in such investigation, and

(II) such information is disclosed only to such officers and employees who are personally and directly engaged in such investigation.

(ii) LIMITATION ON USE OF INFORMATION.—Information disclosed under this subparagraph shall be solely for the use of such officers and employees in locating the missing child, in a grand jury proceeding, or in any preparation for, or investigation which may result in, a judicial or administrative proceeding.

(iii) MISSING CHILD.—For purposes of this subparagraph, the term “missing child” shall have the meaning given such term by section 403 of the Missing Children’s Assistance Act (42 U.S.C. 5772).

(iv) EXPLOITED CHILD.—For purposes of this subparagraph, the term “exploited child” means a minor with respect to whom there is reason to believe that a specified offense against a minor (as defined by section 111(7) of the Sex Offender Registration and Notification Act (42 U.S.C. 16911(7))) has or is occurring.

(2) DISCLOSURE OF RETURN INFORMATION OTHER THAN TAXPAYER RETURN INFORMATION FOR USE IN CRIMINAL INVESTIGATIONS.—

(A) IN GENERAL.—Except as provided in paragraph (6), upon receipt by the Secretary of a request which meets the requirements of subparagraph (B) from the head of any Federal agency or the Inspector General thereof, or, in the case of the Department of Justice, the Attorney General, the Deputy Attorney General, the Associate Attorney General, any Assistant Attorney General, the Director of the Federal Bureau of Investigation, the Administrator of the Drug Enforcement Administration, any United States attorney, any special prosecutor appointed under section 593 of title 28, United States Code, or any attorney in charge of a criminal division organized crime strike force established pursuant to section 510 of title 28, United States Code, the Secretary shall disclose return information (other than taxpayer return information) to officers and employees of such agency who are personally and directly engaged in—

(i) preparation for any judicial or administrative proceeding described in paragraph (1)(A)(i),

(ii) any investigation which may result in such a proceeding, or

(iii) any grand jury proceeding described in paragraph (1)(A)(iii),

solely for the use of such officers and employees in such preparation, investigation, or grand jury proceeding.

(B) REQUIREMENTS.—A request meets the requirements of this subparagraph if the request is in writing and sets forth—

(i) the name and address of the taxpayer with respect to whom the requested return information relates;

(ii) the taxable period or periods to which such return information relates;

(iii) the statutory authority under which the proceeding or investigation described in subparagraph (A) is being conducted; and

(iv) the specific reason or reasons why such disclosure is, or may be, relevant to such proceeding or investigation.

(C) TAXPAYER IDENTITY.—For purposes of this paragraph, a taxpayer's identity shall not be treated as taxpayer return information.

(3) DISCLOSURE OF RETURN INFORMATION TO APPRISE APPROPRIATE OFFICIALS OF CRIMINAL OR TERRORIST ACTIVITIES OR EMERGENCY CIRCUMSTANCES.—

(A) POSSIBLE VIOLATIONS OF FEDERAL CRIMINAL LAW.—

(i) IN GENERAL.—Except as provided in paragraph (6), the Secretary may disclose in writing return information (other than taxpayer return information) which may constitute evidence of a violation of any Federal criminal law (not involving tax administration) to the extent necessary to apprise the head of the appropriate Federal agency charged with the responsibility of enforcing such law. The head of such agency may disclose such return information to officers and employees of such agency to the extent necessary to enforce such law.

(ii) TAXPAYER IDENTITY.—If there is return information (other than taxpayer return information) which may constitute evidence of a violation by any taxpayer of any Federal criminal law (not involving tax administration), such taxpayer's identity may also be disclosed under clause (i).

(B) EMERGENCY CIRCUMSTANCES.—

(i) DANGER OF DEATH OR PHYSICAL INJURY.—Under circumstances involving an imminent danger of death or physical injury to any individual, the Secretary may disclose return information to the extent necessary to apprise appropriate officers or employees of any Federal or State law enforcement agency of such circumstances.

(ii) FLIGHT FROM FEDERAL PROSECUTION.—Under circumstances involving the imminent flight of any individual from Federal prosecution, the Secretary may disclose return information to the extent necessary to apprise appropriate officers or employees of any Federal law enforcement agency of such circumstances.

(C) TERRORIST ACTIVITIES, ETC.—

(i) IN GENERAL.—Except as provided in paragraph (6), the Secretary may disclose in writing return information (other than taxpayer return information) that may be related to a terrorist incident, threat, or activity to the extent necessary to apprise the head of the appropriate Federal law enforcement agency responsible for investigating or responding to such terrorist incident, threat, or activity. The head of the agency may disclose such return information to officers and employees of such agency to the extent necessary to investigate or respond to such terrorist incident, threat, or activity.

(ii) DISCLOSURE TO THE DEPARTMENT OF JUSTICE.—Returns and taxpayer return information may also be disclosed to the Attorney General under clause (i) to the extent necessary for, and solely for use in preparing, an application under paragraph (7)(D).

(iii) TAXPAYER IDENTITY.—For purposes of this subparagraph, a taxpayer's identity shall not be treated as taxpayer return information.

(4) USE OF CERTAIN DISCLOSED RETURNS AND RETURN INFORMATION IN JUDICIAL OR ADMINISTRATIVE PROCEEDINGS.—

(A) RETURNS AND TAXPAYER RETURN INFORMATION.—Except as provided in subparagraph (C), any return or taxpayer return information obtained under paragraph (1) or (7)(C) may be disclosed in any judicial or administrative proceeding pertaining to enforcement of a specifically designated Federal criminal statute or related civil forfeiture (not involving tax administration) to which the United States or a Federal agency is a party—

(i) if the court finds that such return or taxpayer return information is probative of a matter in issue relevant in establishing the commission of a crime or the guilt or liability of a party, or

(ii) to the extent required by order of the court pursuant to section 3500 of title 18, United States Code, or rule 16 of the Federal Rules of Criminal Procedure.

(B) RETURN INFORMATION (OTHER THAN TAXPAYER RETURN INFORMATION).—Except as provided in subparagraph (C), any return information (other than taxpayer return information) obtained under paragraph (1), (2), (3)(A) or (C), or (7) may be disclosed in any judicial or administrative proceeding pertaining to enforcement of a specifically designated Federal criminal statute or related civil forfeiture (not involving tax administration) to which the United States or a Federal agency is a party.

(C) CONFIDENTIAL INFORMANT; IMPAIRMENT OF INVESTIGATIONS.—No return or return information shall be admitted into evidence under subparagraph (A)(i) or (B) if the Secretary determines and notifies the Attorney General or his delegate or the head of the Federal agency that such admission would identify a confidential informant or seriously impair a civil or criminal tax investigation.

(D) CONSIDERATION OF CONFIDENTIALITY POLICY.—In ruling upon the admissibility of returns or return information, and in the issuance of an order under subparagraph (A)(ii), the court shall give due consideration to congressional policy favoring the confidentiality of returns and return information as set forth in this title.

(E) REVERSIBLE ERROR.—The admission into evidence of any return or return information contrary to the provisions of this paragraph shall not, as such, constitute reversible error upon appeal of a judgment in the proceeding.

(5) DISCLOSURE TO LOCATE FUGITIVES FROM JUSTICE.—

(A) IN GENERAL.—Except as provided in paragraph (6), the return of an individual or return information with respect to such individual shall, pursuant to and upon the grant of an ex parte order by a Federal district court judge or magistrate judge under subparagraph (B), be open (but only to the extent necessary as provided in such order) to inspection by, or disclosure to, officers and employees of any Federal agency exclusively for use in locating such individual.

(B) APPLICATION FOR ORDER.—Any person described in paragraph (1)(B) may authorize an application to a Federal district court judge or magistrate judge for an order referred to in subparagraph (A). Upon such application, such judge or magistrate judge may grant such order if he determines on the basis of the facts submitted by the applicant that—

(i) a Federal arrest warrant relating to the commission of a Federal felony offense has been issued for an individual who is a fugitive from justice,

(ii) the return of such individual or return information with respect to such individual is sought exclusively for use in locating such individual, and

(iii) there is reasonable cause to believe that such return or return information may be relevant in determining the location of such individual.

(6) CONFIDENTIAL INFORMANTS; IMPAIRMENT OF INVESTIGATIONS.—The Secretary shall not disclose any return or return information under paragraph (1), (2), (3)(A) or (C), (5), (7), or (8) if the Secretary determines (and, in the case of a request for disclosure pursuant to a court order described in paragraph (1)(B) or (5)(B), certifies to the court) that such disclosure would identify a confidential informant or seriously impair a civil or criminal tax investigation.

(7) DISCLOSURE UPON REQUEST OF INFORMATION RELATING TO TERRORIST ACTIVITIES, ETC.—

(A) DISCLOSURE TO LAW ENFORCEMENT AGENCIES.—

(i) IN GENERAL.—Except as provided in paragraph (6), upon receipt by the Secretary of a written request which meets the requirements of clause (iii), the Secretary may disclose return information (other than taxpayer return information) to officers and employees of any Federal law enforcement agency who are per-

sonally and directly engaged in the response to or investigation of any terrorist incident, threat, or activity.

(ii) DISCLOSURE TO STATE AND LOCAL LAW ENFORCEMENT AGENCIES.—The head of any Federal law enforcement agency may disclose return information obtained under clause (i) to officers and employees of any State or local law enforcement agency but only if such agency is part of a team with the Federal law enforcement agency in such response or investigation and such information is disclosed only to officers and employees who are personally and directly engaged in such response or investigation.

(iii) REQUIREMENTS.—A request meets the requirements of this clause if—

(I) the request is made by the head of any Federal law enforcement agency (or his delegate) involved in the response to or investigation of any terrorist incident, threat, or activity, and

(II) the request sets forth the specific reason or reasons why such disclosure may be relevant to a terrorist incident, threat, or activity.

(iv) LIMITATION ON USE OF INFORMATION.—Information disclosed under this subparagraph shall be solely for the use of the officers and employees to whom such information is disclosed in such response or investigation.

(v) TAXPAYER IDENTITY.—For purposes of this subparagraph, a taxpayer's identity shall not be treated as taxpayer return information.

(B) DISCLOSURE TO INTELLIGENCE AGENCIES.—

(i) IN GENERAL.—Except as provided in paragraph (6), upon receipt by the Secretary of a written request which meets the requirements of clause (ii), the Secretary may disclose return information (other than taxpayer return information) to those officers and employees of the Department of Justice, the Department of the Treasury, and other Federal intelligence agencies who are personally and directly engaged in the collection or analysis of intelligence and counterintelligence information or investigation concerning any terrorist incident, threat, or activity. For purposes of the preceding sentence, the information disclosed under the preceding sentence shall be solely for the use of such officers and employees in such investigation, collection, or analysis.

(ii) REQUIREMENTS.—A request meets the requirements of this subparagraph if the request—

(I) is made by an individual described in clause (iii), and

(II) sets forth the specific reason or reasons why such disclosure may be relevant to a terrorist incident, threat, or activity.

(iii) REQUESTING INDIVIDUALS.—An individual described in this subparagraph is an individual—

(I) who is an officer or employee of the Department of Justice or the Department of the Treasury who is appointed by the President with the advice and consent of the Senate or who is the Director of the United States Secret Service, and

(II) who is responsible for the collection and analysis of intelligence and counterintelligence information concerning any terrorist incident, threat, or activity.

(iv) TAXPAYER IDENTITY.—For purposes of this subparagraph, a taxpayer's identity shall not be treated as taxpayer return information.

(C) DISCLOSURE UNDER EX PARTE ORDERS.—

(i) IN GENERAL.—Except as provided in paragraph (6), any return or return information with respect to any specified taxable period or periods shall, pursuant to and upon the grant of an ex parte order by a Federal district court judge or magistrate judge under clause (ii), be open (but only to the extent necessary as provided in such order) to inspection by, or disclosure to, officers and employees of any Federal law enforcement agency or Federal intelligence agency who are personally and directly engaged in any investigation, response to, or analysis of intelligence and counterintelligence information concerning any terrorist incident, threat, or activity. Return or return information opened to inspection or disclosure pursuant to the preceding sentence shall be solely for the use of such officers and employees in the investigation, response, or analysis, and in any judicial, administrative, or grand jury proceedings, pertaining to such terrorist incident, threat, or activity.

(ii) APPLICATION FOR ORDER.—The Attorney General, the Deputy Attorney General, the Associate Attorney General, any Assistant Attorney General, or any United States attorney may authorize an application to a Federal district court judge or magistrate judge for the order referred to in clause (i). Upon such application, such judge or magistrate judge may grant such order if he determines on the basis of the facts submitted by the applicant that—

(I) there is reasonable cause to believe, based upon information believed to be reliable, that the return or return information may be relevant to a matter relating to such terrorist incident, threat, or activity, and

(II) the return or return information is sought exclusively for use in a Federal investigation, analysis, or proceeding concerning any terrorist incident, threat, or activity.

(D) SPECIAL RULE FOR EX PARTE DISCLOSURE BY THE IRS.—

(i) IN GENERAL.—Except as provided in paragraph (6), the Secretary may authorize an application to a

Federal district court judge or magistrate judge for the order referred to in subparagraph (C)(i). Upon such application, such judge or magistrate judge may grant such order if he determines on the basis of the facts submitted by the applicant that the requirements of subparagraph (C)(ii)(I) are met.

(ii) LIMITATION ON USE OF INFORMATION.—Information disclosed under clause (i)—

(I) may be disclosed only to the extent necessary to apprise the head of the appropriate Federal law enforcement agency responsible for investigating or responding to a terrorist incident, threat, or activity, and

(II) shall be solely for use in a Federal investigation, analysis, or proceeding concerning any terrorist incident, threat, or activity.

The head of such Federal agency may disclose such information to officers and employees of such agency to the extent necessary to investigate or respond to such terrorist incident, threat, or activity.

(8) COMPTROLLER GENERAL.—

(A) RETURNS AVAILABLE FOR INSPECTION.—Except as provided in subparagraph (C), upon written request by the Comptroller General of the United States, returns and return information shall be open to inspection by, or disclosure to, officers and employees of the Government Accountability Office for the purpose of, and to the extent necessary in, making—

(i) an audit of the Internal Revenue Service, the Bureau of Alcohol, Tobacco, Firearms, and Explosives, Department of Justice, or the Tax and Trade Bureau, Department of the Treasury, which may be required by section 713 of title 31, United States Code, or

(ii) any audit authorized by subsection (p)(6), except that no such officer or employee shall, except to the extent authorized by subsection (f) or (p)(6), disclose to any person, other than another officer or employee of such office whose official duties require such disclosure, any return or return information described in section 4424(a) in a form which can be associated with, or otherwise identify, directly or indirectly, a particular taxpayer, nor shall such officer or employee disclose any other return or return information, except as otherwise expressly provided by law, to any person other than such other officer or employee of such office in a form which can be associated with, or otherwise identify, directly or indirectly, a particular taxpayer.

(B) AUDITS OF OTHER AGENCIES.—

(i) IN GENERAL.—Nothing in this section shall prohibit any return or return information obtained under this title by any Federal agency (other than an agency referred to in subparagraph (A)) or by a Trustee as defined in the District of Columbia Retirement Protection Act of 1997, for use in any program or activity

from being open to inspection by, or disclosure to, officers and employees of the Government Accountability Office if such inspection or disclosure is—

(I) for purposes of, and to the extent necessary in, making an audit authorized by law of such program or activity, and

(II) pursuant to a written request by the Comptroller General of the United States to the head of such Federal agency.

(ii) INFORMATION FROM SECRETARY.—If the Comptroller General of the United States determines that the returns or return information available under clause (i) are not sufficient for purposes of making an audit of any program or activity of a Federal agency (other than an agency referred to in subparagraph (A)), upon written request by the Comptroller General to the Secretary, returns and return information (of the type authorized by subsection (l) or (m) to be made available to the Federal agency for use in such program or activity) shall be open to inspection by, or disclosure to, officers and employees of the Government Accountability Office for the purpose of, and to the extent necessary in, making such audit.

(iii) REQUIREMENT OF NOTIFICATION UPON COMPLETION OF AUDIT.—Within 90 days after the completion of an audit with respect to which returns or return information were opened to inspection or disclosed under clause (i) or (ii), the Comptroller General of the United States shall notify in writing the Joint Committee on Taxation of such completion. Such notice shall include—

(I) a description of the use of the returns and return information by the Federal agency involved,

(II) such recommendations with respect to the use of returns and return information by such Federal agency as the Comptroller General deems appropriate, and

(III) a statement on the impact of any such recommendations on confidentiality of returns and return information and the administration of this title.

(iv) CERTAIN RESTRICTIONS MADE APPLICABLE.—The restrictions contained in subparagraph (A) on the disclosure of any returns or return information open to inspection or disclosed under such subparagraph shall also apply to returns and return information open to inspection or disclosed under this subparagraph.

(C) DISAPPROVAL BY JOINT COMMITTEE ON TAXATION.—Returns and return information shall not be open to inspection or disclosed under subparagraph (A) or (B) with respect to an audit—

(i) unless the Comptroller General of the United States notifies in writing the Joint Committee on Taxation of such audit, and

(ii) if the Joint Committee on Taxation disapproves such audit by a vote of at least two-thirds of its members within the 30-day period beginning on the day the Joint Committee on Taxation receives such notice.

(j) STATISTICAL USE.—

(1) DEPARTMENT OF COMMERCE.—Upon request in writing by the Secretary of Commerce, the Secretary shall furnish—

(A) such returns, or return information reflected thereon, to officers and employees of the Bureau of the Census, and

(B) such return information reflected on returns of corporations to officers and employees of the Bureau of Economic Analysis,

as the Secretary may prescribe by regulation for the purpose of, but only to the extent necessary in, the structuring of censuses and national economic accounts and conducting related statistical activities authorized by law.

(2) FEDERAL TRADE COMMISSION.—Upon request in writing by the Chairman of the Federal Trade Commission, the Secretary shall furnish such return information reflected on any return of a corporation with respect to the tax imposed by chapter 1 to officers and employees of the Division of Financial Statistics of the Bureau of Economics of such commission as the Secretary may prescribe by regulation for the purpose of, but only to the extent necessary in, administration by such division of legally authorized economic surveys of corporations.

(3) DEPARTMENT OF TREASURY.—Returns and return information shall be open to inspection by or disclosure to officers and employees of the Department of the Treasury whose official duties require such inspection or disclosure for the purpose of, but only to the extent necessary in, preparing economic or financial forecasts, projections, analyses, and statistical studies and conducting related activities. Such inspection or disclosure shall be permitted only upon written request which sets forth the specific reason or reasons why such inspection or disclosure is necessary and which is signed by the head of the bureau or office of the Department of the Treasury requesting the inspection or disclosure.

(4) ANONYMOUS FORM.—No person who receives a return or return information under this subsection shall disclose such return or return information to any person other than the taxpayer to whom it relates except in a form which cannot be associated with, or otherwise identify, directly or indirectly, a particular taxpayer.

(5) DEPARTMENT OF AGRICULTURE.—Upon request in writing by the Secretary of Agriculture, the Secretary shall furnish such returns, or return information reflected thereon, as the Secretary may prescribe by regulation to officers and employees of the Department of Agriculture whose official duties require access to such returns or information for the purpose of, but only to the extent necessary in, structuring, preparing, and conducting the census of agriculture pursuant to the Census of Agriculture Act of 1997 (Public Law 105-113).

(6) CONGRESSIONAL BUDGET OFFICE.—Upon written request by the Director of the Congressional Budget Office, the Sec-

retary shall furnish to officers and employees of the Congressional Budget Office return information for the purpose of, but only to the extent necessary for, long-term models of the social security and medicare programs.

(k) DISCLOSURE OF CERTAIN RETURNS AND RETURN INFORMATION FOR TAX ADMINISTRATION PURPOSES.—

(1) DISCLOSURE OF ACCEPTED OFFERS-IN-COMPROMISE.—Return information shall be disclosed to members of the general public to the extent necessary to permit inspection of any accepted offer-in-compromise under section 7122 relating to the liability for a tax imposed by this title.

(2) DISCLOSURE OF AMOUNT OF OUTSTANDING LIEN.—If a notice of lien has been filed pursuant to section 6323(f), the amount of the outstanding obligation secured by such lien may be disclosed to any person who furnishes satisfactory written evidence that he has a right in the property subject to such lien or intends to obtain a right in such property.

(3) DISCLOSURE OF RETURN INFORMATION TO CORRECT MISSTATEMENTS OF FACT.—The Secretary may, but only following approval by the Joint Committee on Taxation, disclose such return information or any other information with respect to any specific taxpayer to the extent necessary for tax administration purposes to correct a misstatement of fact published or disclosed with respect to such taxpayer's return or any transaction of the taxpayer with the Internal Revenue Service.

(4) DISCLOSURE OF COMPETENT AUTHORITY UNDER INCOME TAX CONVENTION.—A return or return information may be disclosed to a competent authority of a foreign government which has an income tax or gift and estate tax convention, or other convention or bilateral agreement relating to the exchange of tax information, with the United States but only to the extent provided in, and subject to the terms and conditions of, such convention or bilateral agreement.

(5) STATE AGENCIES REGULATING TAX RETURN PREPARERS.—Taxpayer identity information with respect to any tax return preparer, and information as to whether or not any penalty has been assessed against such tax return preparer under section 6694, 6695, or 7216, may be furnished to any agency, body, or commission lawfully charged under any State or local law with the licensing, registration, or regulation of tax return preparers. Such information may be furnished only upon written request by the head of such agency, body, or commission designating the officers or employees to whom such information is to be furnished. Information may be furnished and used under this paragraph only for purposes of the licensing, registration, or regulation of tax return preparers.

(6) DISCLOSURE BY CERTAIN OFFICERS AND EMPLOYEES FOR INVESTIGATIVE PURPOSES.—An internal revenue officer or employee and an officer or employee of the Office of Treasury Inspector General for Tax Administration may, in connection with his official duties relating to any audit, collection activity, or civil or criminal tax investigation or any other offense under the internal revenue laws, disclose return information to the extent that such disclosure is necessary in obtaining informa-

tion, which is not otherwise reasonably available, with respect to the correct determination of tax, liability for tax, or the amount to be collected or with respect to the enforcement of any other provision of this title. Such disclosures shall be made only in such situations and under such conditions as the Secretary may prescribe by regulation.

(7) DISCLOSURE OF EXCISE TAX REGISTRATION INFORMATION.—To the extent the Secretary determines that disclosure is necessary to permit the effective administration of subtitle D, the Secretary may disclose—

(A) the name, address, and registration number of each person who is registered under any provision of subtitle D (and, in the case of a registered terminal operator, the address of each terminal operated by such operator), and

(B) the registration status of any person.

(8) LEVIES ON CERTAIN GOVERNMENT PAYMENTS.—

(A) DISCLOSURE OF RETURN INFORMATION IN LEVIES ON FINANCIAL MANAGEMENT SERVICE.—In serving a notice of levy, or release of such levy, with respect to any applicable government payment, the Secretary may disclose to officers and employees of the Financial Management Service—

(i) return information, including taxpayer identity information,

(ii) the amount of any unpaid liability under this title (including penalties and interest), and

(iii) the type of tax and tax period to which such unpaid liability relates.

(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Financial Management Service only for the purpose of, and to the extent necessary in, transferring levied funds in satisfaction of the levy, maintaining appropriate agency records in regard to such levy or the release thereof, notifying the taxpayer and the agency certifying such payment that the levy has been honored, or in the defense of any litigation ensuing from the honor of such levy.

(C) APPLICABLE GOVERNMENT PAYMENT.—For purposes of this paragraph, the term “applicable government payment” means—

(i) any Federal payment (other than a payment for which eligibility is based on the income or assets (or both) of a payee) certified to the Financial Management Service for disbursement, and

(ii) any other payment which is certified to the Financial Management Service for disbursement and which the Secretary designates by published notice.

(9) DISCLOSURE OF INFORMATION TO ADMINISTER SECTION 6311.—The Secretary may disclose returns or return information to financial institutions and others to the extent the Secretary deems necessary for the administration of section 6311. Disclosures of information for purposes other than to accept payments by checks or money orders shall be made only to the

extent authorized by written procedures promulgated by the Secretary.

(10) DISCLOSURE OF CERTAIN RETURNS AND RETURN INFORMATION TO CERTAIN PRISON OFFICIALS.—

(A) IN GENERAL.—Under such procedures as the Secretary may prescribe, the Secretary may disclose to officers and employees of the Federal Bureau of Prisons and of any State agency charged with the responsibility for administration of prisons any returns or return information with respect to individuals incarcerated in Federal or State prison systems whom the Secretary has determined may have filed or facilitated the filing of a false or fraudulent return to the extent that the Secretary determines that such disclosure is necessary to permit effective Federal tax administration.

(B) DISCLOSURE TO CONTRACTOR-RUN PRISONS.—Under such procedures as the Secretary may prescribe, the disclosures authorized by subparagraph (A) may be made to contractors responsible for the operation of a Federal or State prison on behalf of such Bureau or agency.

(C) RESTRICTIONS ON USE OF DISCLOSED INFORMATION.—Any return or return information received under this paragraph shall be used only for the purposes of and to the extent necessary in taking administrative action to prevent the filing of false and fraudulent returns, including administrative actions to address possible violations of administrative rules and regulations of the prison facility and in administrative and judicial proceedings arising from such administrative actions.

(D) RESTRICTIONS ON REDISCLOSURE AND DISCLOSURE TO LEGAL REPRESENTATIVES.—Notwithstanding subsection (h)—

(i) RESTRICTIONS ON REDISCLOSURE.—Except as provided in clause (ii), any officer, employee, or contractor of the Federal Bureau of Prisons or of any State agency charged with the responsibility for administration of prisons shall not disclose any information obtained under this paragraph to any person other than an officer or employee or contractor of such Bureau or agency personally and directly engaged in the administration of prison facilities on behalf of such Bureau or agency.

(ii) DISCLOSURE TO LEGAL REPRESENTATIVES.—The returns and return information disclosed under this paragraph may be disclosed to the duly authorized legal representative of the Federal Bureau of Prisons, State agency, or contractor charged with the responsibility for administration of prisons, or of the incarcerated individual accused of filing the false or fraudulent return who is a party to an action or proceeding described in subparagraph (C), solely in preparation for, or for use in, such action or proceeding.

(11) DISCLOSURE OF RETURN INFORMATION TO DEPARTMENT OF STATE FOR PURPOSES OF PASSPORT REVOCATION UNDER SECTION 7345.—

(A) IN GENERAL.—The Secretary shall, upon receiving a certification described in section 7345, disclose to the Secretary of State return information with respect to a taxpayer who has a seriously delinquent tax debt described in such section. Such return information shall be limited to—

- (i) the taxpayer identity information with respect to such taxpayer, and
- (ii) the amount of such seriously delinquent tax debt.

(B) RESTRICTION ON DISCLOSURE.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Department of State for the purposes of, and to the extent necessary in, carrying out the requirements of section 32101 of the FAST Act.

(12) QUALIFIED TAX COLLECTION CONTRACTORS.—Persons providing services pursuant to a qualified tax collection contract under section 6306 may, if speaking to a person who has identified himself or herself as having the name of the taxpayer to which a tax receivable (within the meaning of such section) relates, identify themselves as contractors of the Internal Revenue Service and disclose the business name of the contractor, and the nature, subject, and reason for the contact. Disclosures under this paragraph shall be made only in such situations and under such conditions as have been approved by the Secretary.

(1) DISCLOSURE OF RETURNS AND RETURN INFORMATION FOR PURPOSES OTHER THAN TAX ADMINISTRATION.—

(1) DISCLOSURE OF CERTAIN RETURNS AND RETURN INFORMATION TO SOCIAL SECURITY ADMINISTRATION AND RAILROAD RETIREMENT BOARD.—The Secretary may, upon written request, disclose returns and return information with respect to—

(A) taxes imposed by chapters 2, 21, and 24, to the Social Security Administration for purposes of its administration of the Social Security Act;

(B) a plan to which part I of subchapter D of chapter 1 applies, to the Social Security Administration for purposes of carrying out its responsibility under section 1131 of the Social Security Act, limited, however to return information described in section 6057(d); and

(C) taxes imposed by chapter 22, to the Railroad Retirement Board for purposes of its administration of the Railroad Retirement Act.

(2) DISCLOSURE OF RETURNS AND RETURN INFORMATION TO THE DEPARTMENT OF LABOR AND PENSION BENEFIT GUARANTY CORPORATION.—The Secretary may, upon written request, furnish returns and return information to the proper officers and employees of the Department of Labor and the Pension Benefit Guaranty Corporation for purposes of, but only to the extent necessary in, the administration of titles I and IV of the Employee Retirement Income Security Act of 1974.

(3) DISCLOSURE THAT APPLICANT FOR FEDERAL LOAN HAS TAX DELINQUENT ACCOUNT.—

(A) IN GENERAL.—Upon written request, the Secretary may disclose to the head of the Federal agency administering any included Federal loan program whether or not an applicant for a loan under such program has a tax delinquent account.

(B) RESTRICTION ON DISCLOSURE.—Any disclosure under subparagraph (A) shall be made only for the purpose of, and to the extent necessary in, determining the creditworthiness of the applicant for the loan in question.

(C) INCLUDED FEDERAL LOAN PROGRAM DEFINED.—For purposes of this paragraph, the term “included Federal loan program” means any program under which the United States or a Federal agency makes, guarantees, or insures loans.

(4) DISCLOSURE OF RETURNS AND RETURN INFORMATION FOR USE IN PERSONNEL OR CLAIMANT REPRESENTATIVE MATTERS.—The Secretary may disclose returns and return information—

(A) upon written request—

(i) to an employee or former employee of the Department of the Treasury, or to the duly authorized legal representative of such employee or former employee, who is or may be a party to any administrative action or proceeding affecting the personnel rights of such employee or former employee; or

(ii) to any person, or to the duly authorized legal representative of such person, whose rights are or may be affected by an administrative action or proceeding under section 330 of title 31, United States Code,

solely for use in the action or proceeding, or in preparation for the action or proceeding, but only to the extent that the Secretary determines that such returns or return information is or may be relevant and material to the action or proceeding; or

(B) to officers and employees of the Department of the Treasury for use in any action or proceeding described in subparagraph (A), or in preparation for such action or proceeding, to the extent necessary to advance or protect the interests of the United States.

(5) SOCIAL SECURITY ADMINISTRATION.—Upon written request by the Commissioner of Social Security, the Secretary may disclose information returns filed pursuant to part III of subchapter A of chapter 61 of this subtitle for the purpose of—

(A) carrying out, in accordance with an agreement entered into pursuant to section 232 of the Social Security Act, an effective return processing program; or

(B) providing information regarding the mortality status of individuals for epidemiological and similar research in accordance with section 1106(d) of the Social Security Act.

(6) DISCLOSURE OF RETURN INFORMATION TO FEDERAL, STATE, AND LOCAL CHILD SUPPORT ENFORCEMENT AGENCIES.—

(A) RETURN INFORMATION FROM INTERNAL REVENUE SERVICE.—The Secretary may, upon written request, dis-

close to the appropriate Federal, State, or local child support enforcement agency—

(i) available return information from the master files of the Internal Revenue Service relating to the social security account number (or numbers, if the individual involved has more than one such number), address, filing status, amounts and nature of income, and the number of dependents reported on any return filed by, or with respect to, any individual with respect to whom child support obligations are sought to be established or enforced pursuant to the provisions of part D of title IV of the Social Security Act and with respect to any individual to whom such support obligations are owing, and

(ii) available return information reflected on any return filed by, or with respect to, any individual described in clause (i) relating to the amount of such individual's gross income (as defined in section 61) or consisting of the names and addresses of payors of such income and the names of any dependents reported on such return, but only if such return information is not reasonably available from any other source.

(B) DISCLOSURE TO CERTAIN AGENTS.—The following information disclosed to any child support enforcement agency under subparagraph (A) with respect to any individual with respect to whom child support obligations are sought to be established or enforced may be disclosed by such agency to any agent of such agency which is under contract with such agency to carry out the purposes described in subparagraph (C):

(i) The address and social security account number (or numbers) of such individual.

(ii) The amount of any reduction under section 6402(c) (relating to offset of past-due support against overpayments) in any overpayment otherwise payable to such individual.

(C) RESTRICTION ON DISCLOSURE.—Information may be disclosed under this paragraph only for purposes of, and to the extent necessary in, establishing and collecting child support obligations from, and locating, individuals owing such obligations.

(7) Disclosure of return information to Federal, State, and local agencies administering certain programs under the Social Security Act, the Food and Nutrition Act of 2008 of 1977, or title 38, United States Code, or certain housing assistance programs

(A) RETURN INFORMATION FROM SOCIAL SECURITY ADMINISTRATION.—The Commissioner of Social Security shall, upon written request, disclose return information from returns with respect to net earnings from self-employment (as defined in section 1402), wages (as defined in section 3121(a) or 3401(a)), and payments of retirement income, which have been disclosed to the Social Security Administration as provided by paragraph (1) or (5) of this sub-

section, to any Federal, State, or local agency administering a program listed in subparagraph (D).

(B) RETURN INFORMATION FROM INTERNAL REVENUE SERVICE.—The Secretary shall, upon written request, disclose current return information from returns with respect to unearned income from the Internal Revenue Service files to any Federal, State, or local agency administering a program listed in subparagraph (D).

(C) RESTRICTION ON DISCLOSURE.—The Commissioner of Social Security and the Secretary shall disclose return information under subparagraphs (A) and (B) only for purposes of, and to the extent necessary in, determining eligibility for, or the correct amount of, benefits under a program listed in subparagraph (D).

(D) PROGRAMS TO WHICH RULE APPLIES.—The programs to which this paragraph applies are:

(i) a State program funded under part A of title IV of the Social Security Act;

(ii) medical assistance provided under a State plan approved under title XIX of the Social Security Act or subsidies provided under section 1860D-14 of such Act;

(iii) supplemental security income benefits provided under title XVI of the Social Security Act, and federally administered supplementary payments of the type described in section 1616(a) of such Act (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93-66);

(iv) any benefits provided under a State plan approved under title I, X, XIV, or XVI of the Social Security Act (as those titles apply to Puerto Rico, Guam, and the Virgin Islands);

(v) unemployment compensation provided under a State law described in section 3304 of this title;

(vi) assistance provided under the Food and Nutrition Act of 2008;

(vii) State-administered supplementary payments of the type described in section 1616(a) of the Social Security Act (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93-66);

(viii)(I) any needs-based pension provided under chapter 15 of title 38, United States Code, or under any other law administered by the Secretary of Veterans Affairs;

(II) parents' dependency and indemnity compensation provided under section 1315 of title 38, United States Code;

(III) health-care services furnished under sections 1710(a)(2)(G), 1710(a)(3), and 1710(b) of such title; and

(IV) compensation paid under chapter 11 of title 38, United States Code, at the 100 percent rate based solely on unemployability and without regard to the fact that the disability or disabilities

are not rated as 100 percent disabling under the rating schedule; and

(ix) any housing assistance program administered by the Department of Housing and Urban Development that involves initial and periodic review of an applicant's or participant's income, except that return information may be disclosed under this clause only on written request by the Secretary of Housing and Urban Development and only for use by officers and employees of the Department of Housing and Urban Development with respect to applicants for and participants in such programs.

Only return information from returns with respect to net earnings from self-employment and wages may be disclosed under this paragraph for use with respect to any program described in clause (viii)(IV).

(8) DISCLOSURE OF CERTAIN RETURN INFORMATION BY SOCIAL SECURITY ADMINISTRATION TO FEDERAL, STATE, AND LOCAL CHILD SUPPORT ENFORCEMENT AGENCIES.—

(A) IN GENERAL.—Upon written request, the Commissioner of Social Security shall disclose directly to officers and employees of a Federal or State or local child support enforcement agency return information from returns with respect to social security account numbers, net earnings from self-employment (as defined in section 1402), wages (as defined in section 3121(a) or 3401(a)), and payments of retirement income which have been disclosed to the Social Security Administration as provided by paragraph (1) or (5) of this subsection.

(B) RESTRICTION ON DISCLOSURE.—The Commissioner of Social Security shall disclose return information under subparagraph (A) only for purposes of, and to the extent necessary in, establishing and collecting child support obligations from, and locating, individuals owing such obligations. For purposes of the preceding sentence, the term “child support obligations” only includes obligations which are being enforced pursuant to a plan described in section 454 of the Social Security Act which has been approved by the Secretary of Health and Human Services under part D of title IV of such Act.

(C) STATE OR LOCAL CHILD SUPPORT ENFORCEMENT AGENCY.—For purposes of this paragraph, the term “State or local child support enforcement agency” means any agency of a State or political subdivision thereof operating pursuant to a plan described in subparagraph (B).

(9) DISCLOSURE OF ALCOHOL FUEL PRODUCERS TO ADMINISTRATORS OF STATE ALCOHOL LAWS.—Notwithstanding any other provision of this section, the Secretary may disclose—

(A) the name and address of any person who is qualified to produce alcohol for fuel use under section 5181, and

(B) the location of any premises to be used by such person in producing alcohol for fuel,
to any State agency, body, or commission, or its legal representative, which is charged under the laws of such State

with responsibility for administration of State alcohol laws solely for use in the administration of such laws.

(10) DISCLOSURE OF CERTAIN INFORMATION TO AGENCIES REQUESTING A REDUCTION UNDER SUBSECTION (C), (D), (E), OR (F) OF SECTION 6402.—

(A) RETURN INFORMATION FROM INTERNAL REVENUE SERVICE.—The Secretary may, upon receiving a written request, disclose to officers and employees of any agency seeking a reduction under subsection (c), (d), (e), or (f) of section 6402, to officers and employees of the Department of Labor for purposes of facilitating the exchange of data in connection with a request made under subsection (f)(5) of section 6402, and to officers and employees of the Department of the Treasury in connection with such reduction—

(i) taxpayer identity information with respect to the taxpayer against whom such a reduction was made or not made and with respect to any other person filing a joint return with such taxpayer,

(ii) the fact that a reduction has been made or has not been made under such subsection with respect to such taxpayer,

(iii) the amount of such reduction,

(iv) whether such taxpayer filed a joint return, and

(v) the fact that a payment was made (and the amount of the payment) to the spouse of the taxpayer on the basis of a joint return.

(B)(i) Restriction on use of disclosed information

Any officers and employees of an agency receiving return information under subparagraph (A) shall use such information only for the purposes of, and to the extent necessary in, establishing appropriate agency records, locating any person with respect to whom a reduction under subsection (c), (d), (e), or (f) of section 6402 is sought for purposes of collecting the debt with respect to which the reduction is sought, or in the defense of any litigation or administrative procedure ensuing from a reduction made under subsection (c), (d), (e), or (f) of section 6402 and to officers and employees of the Department of the Treasury in connection with such reduction.

(ii) Notwithstanding clause (i), return information disclosed to officers and employees of the Department of Labor may be accessed by agents who maintain and provide technological support to the Department of Labor's Interstate Connection Network (ICON) solely for the purpose of providing such maintenance and support.

(11) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT FEDERAL EMPLOYEES' RETIREMENT SYSTEM.—

(A) IN GENERAL.—The Commissioner of Social Security shall, on written request, disclose to the Office of Personnel Management return information from returns with respect to net earnings from self-employment (as defined in section 1402), wages (as defined in section 3121(a) or

3401(a)), and payments of retirement income, which have been disclosed to the Social Security Administration as provided by paragraph (1) or (5).

(B) RESTRICTION ON DISCLOSURE.—The Commissioner of Social Security shall disclose return information under subparagraph (A) only for purposes of, and to the extent necessary in, the administration of chapters 83 and 84 of title 5, United States Code.

(12) DISCLOSURE OF CERTAIN TAXPAYER IDENTITY INFORMATION FOR VERIFICATION OF EMPLOYMENT STATUS OF MEDICARE BENEFICIARY AND SPOUSE OF MEDICARE BENEFICIARY.—

(A) RETURN INFORMATION FROM INTERNAL REVENUE SERVICE.—The Secretary shall, upon written request from the Commissioner of Social Security, disclose to the Commissioner available filing status and taxpayer identity information from the individual master files of the Internal Revenue Service relating to whether any medicare beneficiary identified by the Commissioner was a married individual (as defined in section 7703) for any specified year after 1986, and, if so, the name of the spouse of such individual and such spouse's TIN.

(B) RETURN INFORMATION FROM SOCIAL SECURITY ADMINISTRATION.—The Commissioner of Social Security shall, upon written request from the Administrator of the Centers for Medicare & Medicaid Services, disclose to the Administrator the following information:

(i) The name and TIN of each medicare beneficiary who is identified as having received wages (as defined in section 3401(a)), above an amount (if any) specified by the Secretary of Health and Human Services, from a qualified employer in a previous year.

(ii) For each medicare beneficiary who was identified as married under subparagraph (A) and whose spouse is identified as having received wages, above an amount (if any) specified by the Secretary of Health and Human Services, from a qualified employer in a previous year—

(I) the name and TIN of the medicare beneficiary, and

(II) the name and TIN of the spouse.

(iii) With respect to each such qualified employer, the name, address, and TIN of the employer and the number of individuals with respect to whom written statements were furnished under section 6051 by the employer with respect to such previous year.

(C) DISCLOSURE BY CENTERS FOR MEDICARE & MEDICAID SERVICES.—With respect to the information disclosed under subparagraph (B), the Administrator of the Centers for Medicare & Medicaid Services may disclose—

(i) to the qualified employer referred to in such subparagraph the name and TIN of each individual identified under such subparagraph as having received wages from the employer (hereinafter in this subparagraph referred to as the “employee”) for purposes of

determining during what period such employee or the employee's spouse may be (or have been) covered under a group health plan of the employer and what benefits are or were covered under the plan (including the name, address, and identifying number of the plan),

(ii) to any group health plan which provides or provided coverage to such an employee or spouse, the name of such employee and the employee's spouse (if the spouse is a medicare beneficiary) and the name and address of the employer, and, for the purpose of presenting a claim to the plan—

(I) the TIN of such employee if benefits were paid under title XVIII of the Social Security Act with respect to the employee during a period in which the plan was a primary plan (as defined in section 1862(b)(2)(A) of the Social Security Act), and

(II) the TIN of such spouse if benefits were paid under such title with respect to the spouse during such period, and

(iii) to any agent of such Administrator the information referred to in subparagraph (B) for purposes of carrying out clauses (i) and (ii) on behalf of such Administrator.

(D) SPECIAL RULES.—

(i) RESTRICTIONS ON DISCLOSURE.—Information may be disclosed under this paragraph only for purposes of, and to the extent necessary in, determining the extent to which any medicare beneficiary is covered under any group health plan.

(ii) TIMELY RESPONSE TO REQUESTS.—Any request made under subparagraph (A) or (B) shall be complied with as soon as possible but in no event later than 120 days after the date the request was made.

(E) DEFINITIONS.—For purposes of this paragraph—

(i) MEDICARE BENEFICIARY.—The term “medicare beneficiary” means an individual entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act, but does not include such an individual enrolled in part A under section 1818.

(ii) GROUP HEALTH PLAN.—The term “group health plan” means any group health plan (as defined in section 5000(b)(1)).

(iii) QUALIFIED EMPLOYER.—The term “qualified employer” means, for a calendar year, an employer which has furnished written statements under section 6051 with respect to at least 20 individuals for wages paid in the year.

(13) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT INCOME CONTINGENT REPAYMENT OF STUDENT LOANS.—

(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Education, disclose to officers and employees of the Department of Education return in-

formation with respect to a taxpayer who has received an applicable student loan and whose loan repayment amounts are based in whole or in part on the taxpayer's income. Such return information shall be limited to—

- (i) taxpayer identity information with respect to such taxpayer,
- (ii) the filing status of such taxpayer, and
- (iii) the adjusted gross income of such taxpayer.

(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Department of Education only for the purposes of, and to the extent necessary in, establishing the appropriate income contingent repayment amount for an applicable student loan.

(C) APPLICABLE STUDENT LOAN.—For purposes of this paragraph, the term “applicable student loan” means—

- (i) any loan made under the program authorized under part D of title IV of the Higher Education Act of 1965, and
- (ii) any loan made under part B or E of title IV of the Higher Education Act of 1965 which is in default and has been assigned to the Department of Education.

(D) TERMINATION.—This paragraph shall not apply to any request made after December 31, 2007.

(14) DISCLOSURE OF RETURN INFORMATION TO UNITED STATES CUSTOMS SERVICE.—The Secretary may, upon written request from the Commissioner of the United States Customs Service, disclose to officers and employees of the Department of the Treasury such return information with respect to taxes imposed by chapters 1 and 6 as the Secretary may prescribe by regulations, solely for the purpose of, and only to the extent necessary in—

(A) ascertaining the correctness of any entry in audits as provided for in section 509 of the Tariff Act of 1930 (19 U.S.C. 1509), or

(B) other actions to recover any loss of revenue, or to collect duties, taxes, and fees, determined to be due and owing pursuant to such audits.

(15) DISCLOSURE OF RETURNS FILED UNDER SECTION 6050I.—The Secretary may, upon written request, disclose to officers and employees of—

(A) any Federal agency,

(B) any agency of a State or local government, or

(C) any agency of the government of a foreign country, information contained on returns filed under section 6050I. Any such disclosure shall be made on the same basis, and subject to the same conditions, as apply to disclosures of information on reports filed under section 5313 of title 31, United States Code; except that no disclosure under this paragraph shall be made for purposes of the administration of any tax law.

(16) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF ADMINISTERING THE DISTRICT OF COLUMBIA RETIREMENT PROTECTION ACT OF 1997.—

(A) IN GENERAL.—Upon written request available return information (including such information disclosed to the Social Security Administration under paragraph (1) or (5) of this subsection), relating to the amount of wage income (as defined in section 3121(a) or 3401(a)), the name, address, and identifying number assigned under section 6109, of payors of wage income, taxpayer identity (as defined in subsection 6103 (b)(6)), and the occupational status reflected on any return filed by, or with respect to, any individual with respect to whom eligibility for, or the correct amount of, benefits under the District of Columbia Retirement Protection Act of 1997, is sought to be determined, shall be disclosed by the Commissioner of Social Security, or to the extent not available from the Social Security Administration, by the Secretary, to any duly authorized officer or employee of the Department of the Treasury, or a Trustee or any designated officer or employee of a Trustee (as defined in the District of Columbia Retirement Protection Act of 1997), or any actuary engaged by a Trustee under the terms of the District of Columbia Retirement Protection Act of 1997, whose official duties require such disclosure, solely for the purpose of, and to the extent necessary in, determining an individual's eligibility for, or the correct amount of, benefits under the District of Columbia Retirement Protection Act of 1997.

(B) DISCLOSURE FOR USE IN JUDICIAL OR ADMINISTRATIVE PROCEEDINGS.—Return information disclosed to any person under this paragraph may be disclosed in a judicial or administrative proceeding relating to the determination of an individual's eligibility for, or the correct amount of, benefits under the District of Columbia Retirement Protection Act of 1997.

(17) DISCLOSURE TO NATIONAL ARCHIVES AND RECORDS ADMINISTRATION.—The Secretary shall, upon written request from the Archivist of the United States, disclose or authorize the disclosure of returns and return information to officers and employees of the National Archives and Records Administration for purposes of, and only to the extent necessary in, the appraisal of records for destruction or retention. No such officer or employee shall, except to the extent authorized by subsection (f), (i)(8), or (p), disclose any return or return information disclosed under the preceding sentence to any person other than to the Secretary, or to another officer or employee of the National Archives and Records Administration whose official duties require such disclosure for purposes of such appraisal.

(18) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF CARRYING OUT A PROGRAM FOR ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.—The Secretary may disclose to providers of health insurance for any certified individual (as defined in section 7527(c)) return infor-

mation with respect to such certified individual only to the extent necessary to carry out the program established by section 7527 (relating to advance payment of credit for health insurance costs of eligible individuals).

(19) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF PROVIDING TRANSITIONAL ASSISTANCE UNDER MEDICARE DISCOUNT CARD PROGRAM.—

(A) IN GENERAL.—The Secretary, upon written request from the Secretary of Health and Human Services pursuant to carrying out section 1860D-31 of the Social Security Act, shall disclose to officers, employees, and contractors of the Department of Health and Human Services with respect to a taxpayer for the applicable year—

(i)(I) whether the adjusted gross income, as modified in accordance with specifications of the Secretary of Health and Human Services for purposes of carrying out such section, of such taxpayer and, if applicable, such taxpayer's spouse, for the applicable year, exceeds the amounts specified by the Secretary of Health and Human Services in order to apply the 100 and 135 percent of the poverty lines under such section, (II) whether the return was a joint return, and (III) the applicable year, or

(ii) if applicable, the fact that there is no return filed for such taxpayer for the applicable year.

(B) DEFINITION OF APPLICABLE YEAR.—For the purposes of this subsection, the term “applicable year” means the most recent taxable year for which information is available in the Internal Revenue Service's taxpayer data information systems, or, if there is no return filed for such taxpayer for such year, the prior taxable year.

(C) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under this paragraph may be used only for the purposes of determining eligibility for and administering transitional assistance under section 1860D-31 of the Social Security Act.

(20) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT MEDICARE PART B PREMIUM SUBSIDY ADJUSTMENT AND PART D BASE BENEFICIARY PREMIUM INCREASE.—

(A) IN GENERAL.—The Secretary shall, upon written request from the Commissioner of Social Security, disclose to officers, employees, and contractors of the Social Security Administration return information of a taxpayer whose premium (according to the records of the Secretary) may be subject to adjustment under section 1839(i) or increase under section 1860D-13(a)(7) of the Social Security Act. Such return information shall be limited to—

(i) taxpayer identity information with respect to such taxpayer,

(ii) the filing status of such taxpayer,

(iii) the adjusted gross income of such taxpayer,

(iv) the amounts excluded from such taxpayer's gross income under sections 135 and 911 to the extent such information is available,

(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available,

(vi) the amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available,

(vii) such other information relating to the liability of the taxpayer as is prescribed by the Secretary by regulation as might indicate in the case of a taxpayer who is an individual described in subsection (i)(4)(B)(iii) of section 1839 of the Social Security Act that the amount of the premium of the taxpayer under such section may be subject to adjustment under subsection (i) of such section or increase under section 1860D-13(a)(7) of such Act and the amount of such adjustment, and

(viii) the taxable year with respect to which the preceding information relates.

(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—

(i) IN GENERAL.—Return information disclosed under subparagraph (A) may be used by officers, employees, and contractors of the Social Security Administration only for the purposes of, and to the extent necessary in, establishing the appropriate amount of any premium adjustment under such section 1839(i) or increase under such section 1860D-13(a)(7) or for the purpose of resolving taxpayer appeals with respect to any such premium adjustment or increase.

(ii) DISCLOSURE TO OTHER AGENCIES.—Officers, employees, and contractors of the Social Security Administration may disclose—

(I) the taxpayer identity information and the amount of the premium subsidy adjustment or premium increase with respect to a taxpayer described in subparagraph (A) to officers, employees, and contractors of the Centers for Medicare and Medicaid Services, to the extent that such disclosure is necessary for the collection of the premium subsidy amount or the increased premium amount,

(II) the taxpayer identity information and the amount of the premium subsidy adjustment or the increased premium amount with respect to a taxpayer described in subparagraph (A) to officers and employees of the Office of Personnel Management and the Railroad Retirement Board, to the extent that such disclosure is necessary for the collection of the premium subsidy amount or the increased premium amount,

(III) return information with respect to a taxpayer described in subparagraph (A) to officers and employees of the Department of Health and Human Services to the extent necessary to resolve

administrative appeals of such premium subsidy adjustment or increased premium, and

(IV) return information with respect to a taxpayer described in subparagraph (A) to officers and employees of the Department of Justice for use in judicial proceedings to the extent necessary to carry out the purposes described in clause (i).

(21) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.—

(A) IN GENERAL.—The Secretary, upon written request from the Secretary of Health and Human Services, shall disclose to officers, employees, and contractors of the Department of Health and Human Services return information of any taxpayer whose income is relevant in determining **any premium tax credit under section 36B or any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act or** *any credit under section 36C* eligibility for participation in a State medicaid program under title XIX of the Social Security Act~~], a State's children's health insurance program under title XXI of the Social Security Act, or a basic health program under section 1331 of Patient Protection and Affordable Care Act~~ *or a State's children's health insurance program under title XXI of the Social Security Act*. Such return information shall be limited to—

(i) taxpayer identity information with respect to such taxpayer,

(ii) the filing status of such taxpayer,

(iii) the number of individuals for whom a deduction is allowed under section 151 with respect to the taxpayer (including the taxpayer and the taxpayer's spouse),

(iv) the modified adjusted gross income **[(as defined in section 36B)]** *(as defined in section 36C(c)(2)(B))* of such taxpayer and each of the other individuals included under clause (iii) who are required to file a return of tax imposed by chapter 1 for the taxable year,

(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such credit **[or reduction]** (and the amount thereof), and

(vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

(B) INFORMATION TO EXCHANGE AND STATE AGENCIES.—The Secretary of Health and Human Services **[may disclose to an Exchange]** *may disclose—*

(i) to an Exchange established under the Patient Protection and Affordable Care Act or its contractors, or to a State agency administering a State program described in subparagraph (A) or its contractors, any inconsistency between the information provided by the Exchange or State agency to the Secretary and the in-

formation provided to the Secretary under subparagraph (A) **[.], and**

(ii) *in the case of any credit under section 36C with respect to any health insurance, the amount of such credit (or the amount of any advance payment of such credit) to the provider of such insurance (or, as the Secretary determines appropriate, the licensed agent or broker with respect to such insurance).*

(C) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) or (B) may be used by officers, employees, and contractors of the Department of Health and Human Services, an Exchange, or a State agency only for the purposes of, and to the extent necessary in—

(i) establishing eligibility for participation in the Exchange, and verifying the appropriate **[amount of, any credit or reduction]** *amount of any credit* described in subparagraph (A),

(ii) determining eligibility for participation in the State programs described in subparagraph (A).

(22) DISCLOSURE OF RETURN INFORMATION TO DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR PURPOSES OF ENHANCING MEDICARE PROGRAM INTEGRITY.—

(A) IN GENERAL.—The Secretary shall, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Department of Health and Human Services return information with respect to a taxpayer who has applied to enroll, or reenroll, as a provider of services or supplier under the Medicare program under title XVIII of the Social Security Act. Such return information shall be limited to—

(i) the taxpayer identity information with respect to such taxpayer;

(ii) the amount of the delinquent tax debt owed by that taxpayer; and

(iii) the taxable year to which the delinquent tax debt pertains.

(B) RESTRICTION ON DISCLOSURE.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Department of Health and Human Services for the purposes of, and to the extent necessary in, establishing the taxpayer's eligibility for enrollment or reenrollment in the Medicare program, or in any administrative or judicial proceeding relating to, or arising from, a denial of such enrollment or reenrollment, or in determining the level of enhanced oversight to be applied with respect to such taxpayer pursuant to section 1866(j)(3) of the Social Security Act.

(C) DELINQUENT TAX DEBT.—For purposes of this paragraph, the term “delinquent tax debt” means an outstanding debt under this title for which a notice of lien has been filed pursuant to section 6323, but the term does not include a debt that is being paid in a timely manner pursuant to an agreement under section 6159 or 7122, or a

debt with respect to which a collection due process hearing under section 6330 is requested, pending, or completed and no payment is required.

(m) DISCLOSURE OF TAXPAYER IDENTITY INFORMATION.—

(1) TAX REFUNDS.—The Secretary may disclose taxpayer identity information to the press and other media for purposes of notifying persons entitled to tax refunds when the Secretary, after reasonable effort and lapse of time, has been unable to locate such persons.

(2) FEDERAL CLAIMS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary may, upon written request, disclose the mailing address of a taxpayer for use by officers, employees, or agents of a Federal agency for purposes of locating such taxpayer to collect or compromise a Federal claim against the taxpayer in accordance with sections 3711, 3717, and 3718 of title 31.

(B) SPECIAL RULE FOR CONSUMER REPORTING AGENCY.—In the case of an agent of a Federal agency which is a consumer reporting agency (within the meaning of section 603(f) of the Fair Credit Reporting Act (15 U.S.C. 1681a(f))), the mailing address of a taxpayer may be disclosed to such agent under subparagraph (A) only for the purpose of allowing such agent to prepare a commercial credit report on the taxpayer for use by such Federal agency in accordance with sections 3711, 3717, and 3718 of title 31.

(3) NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH.—Upon written request, the Secretary may disclose the mailing address of taxpayers to officers and employees of the National Institute for Occupational Safety and Health solely for the purpose of locating individuals who are, or may have been, exposed to occupational hazards in order to determine the status of their health or to inform them of the possible need for medical care and treatment.

(4) INDIVIDUALS WHO OWE AN OVERPAYMENT OF FEDERAL PELL GRANTS OR WHO HAVE DEFAULTED ON STUDENT LOANS ADMINISTERED BY THE DEPARTMENT OF EDUCATION.—

(A) IN GENERAL.—Upon written request by the Secretary of Education, the Secretary may disclose the mailing address of any taxpayer—

(i) who owes an overpayment of a grant awarded to such taxpayer under subpart 1 of part A of title IV of the Higher Education Act of 1965, or

(ii) who has defaulted on a loan—

(I) made under part B, D, or E of title IV of the Higher Education Act of 1965, or

(II) made pursuant to section 3(a)(1) of the Migration and Refugee Assistance Act of 1962 to a student at an institution of higher education,

for use only by officers, employees, or agents of the Department of Education for purposes of locating such taxpayer for purposes of collecting such overpayment or loan.

(B) DISCLOSURE TO EDUCATIONAL INSTITUTIONS, ETC.—Any mailing address disclosed under subparagraph (A)(i) may be disclosed by the Secretary of Education to—

(i) any lender, or any State or nonprofit guarantee agency, which is participating under part B or D of title IV of the Higher Education Act of 1965, or

(ii) any educational institution with which the Secretary of Education has an agreement under subpart 1 of part A, or part D or E, of title IV of such Act, for use only by officers, employees, or agents of such lender, guarantee agency, or institution whose duties relate to the collection of student loans for purposes of locating individuals who have defaulted on student loans made under such loan programs for purposes of collecting such loans.

(5) INDIVIDUALS WHO HAVE DEFAULTED ON STUDENT LOANS ADMINISTERED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—

(A) IN GENERAL.—Upon written request by the Secretary of Health and Human Services, the Secretary may disclose the mailing address of any taxpayer who has defaulted on a loan made under part C of title VII of the Public Health Service Act or under subpart II of part B of title VIII of such Act, for use only by officers, employees, or agents of the Department of Health and Human Services for purposes of locating such taxpayer for purposes of collecting such loan.

(B) DISCLOSURE TO SCHOOLS AND ELIGIBLE LENDERS.—Any mailing address disclosed under subparagraph (A) may be disclosed by the Secretary of Health and Human Services to—

(i) any school with which the Secretary of Health and Human Services has an agreement under subpart II of part C of title VII of the Public Health Service Act or subpart II of part B of title VIII of such Act, or

(ii) any eligible lender (within the meaning of section 737(4) of such Act) participating under subpart I of part C of title VII of such Act, for use only by officers, employees, or agents of such school or eligible lender whose duties relate to the collection of student loans for purposes of locating individuals who have defaulted on student loans made under such subparts for the purposes of collecting such loans.

(6) BLOOD DONOR LOCATOR SERVICE.—

(A) IN GENERAL.—Upon written request pursuant to section 1141 of the Social Security Act, the Secretary shall disclose the mailing address of taxpayers to officers and employees of the Blood Donor Locator Service in the Department of Health and Human Services.

(B) RESTRICTION ON DISCLOSURE.—The Secretary shall disclose return information under subparagraph (A) only for purposes of, and to the extent necessary in, assisting under the Blood Donor Locator Service authorized persons (as defined in section 1141(h)(1) of the Social Security Act)

in locating blood donors who, as indicated by donated blood or products derived therefrom or by the history of the subsequent use of such blood or blood products, have or may have the virus for acquired immune deficiency syndrome, in order to inform such donors of the possible need for medical care and treatment.

(C) SAFEGUARDS.—The Secretary shall destroy all related blood donor records (as defined in section 1141(h)(2) of the Social Security Act) in the possession of the Department of the Treasury upon completion of their use in making the disclosure required under subparagraph (A), so as to make such records undisclosable.

(7) SOCIAL SECURITY ACCOUNT STATEMENT FURNISHED BY SOCIAL SECURITY ADMINISTRATION.—Upon written request by the Commissioner of Social Security, the Secretary may disclose the mailing address of any taxpayer who is entitled to receive a social security account statement pursuant to section 1143(c) of the Social Security Act, for use only by officers, employees or agents of the Social Security Administration for purposes of mailing such statement to such taxpayer.

(n) CERTAIN OTHER PERSONS.—Pursuant to regulations prescribed by the Secretary, returns and return information may be disclosed to any person, including any person described in section 7513(a), to the extent necessary in connection with the processing, storage, transmission, and reproduction of such returns and return information, the programming, maintenance, repair, testing, and procurement of equipment, and the providing of other services, for purposes of tax administration.

(o) DISCLOSURE OF RETURNS AND RETURN INFORMATION WITH RESPECT TO CERTAIN TAXES.—

(1) TAXES IMPOSED BY SUBTITLE E.—

(A) IN GENERAL.—Returns and return information with respect to taxes imposed by subtitle E (relating to taxes on alcohol, tobacco, and firearms) shall be open to inspection by or disclosure to officers and employees of a Federal agency whose official duties require such inspection or disclosure.

(B) USE IN CERTAIN PROCEEDINGS.—Returns and return information disclosed to a Federal agency under subparagraph (A) may be used in an action or proceeding (or in preparation for such action or proceeding) brought under section 625 of the American Jobs Creation Act of 2004 for the collection of any unpaid assessment or penalty arising under such Act.

(2) TAXES IMPOSED BY CHAPTER 35.—Returns and return information with respect to taxes imposed by chapter 35 (relating to taxes on wagering) shall, notwithstanding any other provision of this section, be open to inspection by or disclosure only to such person or persons and for such purpose or purposes as are prescribed by section 4424.

(p) PROCEDURE AND RECORDKEEPING.—

(1) MANNER, TIME, AND PLACE OF INSPECTIONS.—Requests for the inspection or disclosure of a return or return information and such inspection or disclosure shall be made in such man-

ner and at such time and place as shall be prescribed by the Secretary.

(2) PROCEDURE.—

(A) REPRODUCTION OF RETURNS.—A reproduction or certified reproduction of a return shall, upon written request, be furnished to any person to whom disclosure or inspection of such return is authorized under this section. A reasonable fee may be prescribed for furnishing such reproduction or certified reproduction.

(B) DISCLOSURE OF RETURN INFORMATION.—Return information disclosed to any person under the provisions of this title may be provided in the form of written documents, reproductions of such documents, films or photoimpressions, or electronically produced tapes, disks, or records, or by any other mode or means which the Secretary determines necessary or appropriate. A reasonable fee may be prescribed for furnishing such return information.

(C) USE OF REPRODUCTIONS.—Any reproduction of any return, document, or other matter made in accordance with this paragraph shall have the same legal status as the original, and any such reproduction shall, if properly authenticated, be admissible in evidence in any judicial or administrative proceeding as if it were the original, whether or not the original is in existence.

(3) RECORDS OF INSPECTION AND DISCLOSURE.—

(A) SYSTEM OF RECORDKEEPING.—Except as otherwise provided by this paragraph, the Secretary shall maintain a permanent system of standardized records or accountings of all requests for inspection or disclosure of returns and return information (including the reasons for and dates of such requests) and of returns and return information inspected or disclosed under this section and section 6104(c). Notwithstanding the provisions of section 552a(c) of title 5, United States Code, the Secretary shall not be required to maintain a record or accounting of requests for inspection or disclosure of returns and return information, or of returns and return information inspected or disclosed, under the authority of subsections (c), (e), (f)(5), (h)(1), (3)(A), or (4), (i)(4), or (8)(A)(ii), (k)(1), (2), (6), (8), or (9), (l)(1), (4)(B), (5), (7), (8), (9), (10), (11), (12), (13), (14), (15), (16), (17), or (18), (m), or (n). The records or accountings required to be maintained under this paragraph shall be available for examination by the Joint Committee on Taxation or the Chief of Staff of such joint committee. Such record or accounting shall also be available for examination by such person or persons as may be, but only to the extent, authorized to make such examination under section 552a(c)(3) of title 5, United States Code.

(B) REPORT BY THE SECRETARY.—The Secretary shall, within 90 days after the close of each calendar year, furnish to the Joint Committee on Taxation a report with respect to, or summary of, the records or accountings described in subparagraph (A) in such form and containing such information as such joint committee or the Chief of

Staff of such joint committee may designate. Such report or summary shall not, however, include a record or accounting of any request by the President under subsection (g) for, or the disclosure in response to such request of, any return or return information with respect to any individual who, at the time of such request, was an officer or employee of the executive branch of the Federal Government. Such report or summary, or any part thereof, may be disclosed by such joint committee to such persons and for such purposes as the joint committee may, by record vote of a majority of the members of the joint committee, determine.

(C) PUBLIC REPORT ON DISCLOSURES.—The Secretary shall, within 90 days after the close of each calendar year, furnish to the Joint Committee on Taxation for disclosure to the public a report with respect to the records or accountings described in subparagraph (A) which—

(i) provides with respect to each Federal agency, each agency, body, or commission described in subsection (d), (i)(3)(B)(i) or (7)(A)(ii), or (l)(6), and the Government Accountability Office the number of—

(I) requests for disclosure of returns and return information,

(II) instances in which returns and return information were disclosed pursuant to such requests or otherwise,

(III) taxpayers whose returns, or return information with respect to whom, were disclosed pursuant to such requests, and

(ii) describes the general purposes for which such requests were made,

(4) SAFEGUARDS.—Any Federal agency described in subsection (h)(2), (h)(5), (i)(1), (2), (3), (5), or (7), (j)(1), (2), or (5), (k)(8), (10), or (11), (l)(1), (2), (3), (5), (10), (11), (13), (14), (17), or (22) or (o)(1)(A), the Government Accountability Office, the Congressional Budget Office, or any agency, body, or commission described in subsection (d), (i)(1)(C), (3)(B)(i), or 7(A)(ii), or (k)(10), (l)(6), (7), (8), (9), (12), (15), or (16), any appropriate State officer (as defined in section 6104(c)), or any other person described in subsection (k)(10), subsection (l)(10), (16), (18), (19), or (20), or any entity described in subsection (l)(21), shall, as a condition for receiving returns or return information—

(A) establish and maintain, to the satisfaction of the Secretary, a permanent system of standardized records with respect to any request, the reason for such request, and the date of such request made by or of it and any disclosure of return or return information made by or to it;

(B) establish and maintain, to the satisfaction of the Secretary, a secure area or place in which such returns or return information shall be stored;

(C) restrict, to the satisfaction of the Secretary, access to the returns or return information only to persons whose duties or responsibilities require access and to whom disclosure may be made under the provisions of this title;

(D) provide such other safeguards which the Secretary determines (and which he prescribes in regulations) to be necessary or appropriate to protect the confidentiality of the returns or return information;

(E) furnish a report to the Secretary, at such time and containing such information as the Secretary may prescribe, which describes the procedures established and utilized by such agency, body, or commission, the Government Accountability Office, or the Congressional Budget Office for ensuring the confidentiality of returns and return information required by this paragraph; and

(F) upon completion of use of such returns or return information—

(i) in the case of an agency, body, or commission described in subsection (d), (i)(3)(B)(i), (k)(10), or (l)(6), (7), (8), (9), or (16), any appropriate State officer (as defined in section 6104(c)), or any other person described in subsection (k)(10) or subsection (l)(10), (16), (18), (19), or (20) return to the Secretary such returns or return information (along with any copies made therefrom) or make such returns or return information undisclosable in any manner and furnish a written report to the Secretary describing such manner,

(ii) in the case of an agency described in subsections (h)(2), (h)(5), (i)(1), (2), (3), (5) or (7), (j)(1), (2), or (5), (k)(8), (10), or (11), (l)(1), (2), (3), (5), (10), (11), (12), (13), (14), (15), (17), or (22), or (o)(1)(A) or any entity described in subsection (l)(21),,, the Government Accountability Office, or the Congressional Budget Office, either—

(I) return to the Secretary such returns or return information (along with any copies made therefrom),

(II) otherwise make such returns or return information undisclosable, or

(III) to the extent not so returned or made undisclosable, ensure that the conditions of subparagraphs (A), (B), (C), (D), and (E) of this paragraph continue to be met with respect to such returns or return information, and

(iii) in the case of the Department of Health and Human Services for purposes of subsection (m)(6), destroy all such return information upon completion of its use in providing the notification for which the information was obtained, so as to make such information undisclosable;

except that the conditions of subparagraphs (A), (B), (C), (D), and (E) shall cease to apply with respect to any return or return information if, and to the extent that, such return or return information is disclosed in the course of any judicial or administrative proceeding and made a part of the public record thereof. If the Secretary determines that any such agency, body, or commission, including an agency, an appropriate State officer (as defined in section 6104(c)), or any other person de-

scribed in subsection (k)(10) or subsection (l)(10), (16), (18), (19), or (20) or any entity described in subsection (l)(21), or the Government Accountability Office or the Congressional Budget Office, has failed to, or does not, meet the requirements of this paragraph, he may, after any proceedings for review established under paragraph (7), take such actions as are necessary to ensure such requirements are met, including refusing to disclose returns or return information to such agency, body, or commission, including an agency, an appropriate State officer (as defined in section 6104(c)), or any other person described in subsection (k)(10) or subsection (l)(10), (16), (18), (19), or (20) or any entity described in subsection (l)(21), or the Government Accountability Office or the Congressional Budget Office, until he determines that such requirements have been or will be met. In the case of any agency which receives any mailing address under paragraph (2), (4), (6), or (7) of subsection (m) and which discloses any such mailing address to any agent or which receives any information under paragraph (6)(A), (10), (12)(B), or (16) of subsection (l) and which discloses any such information to any agent, or any person including an agent described in subsection (l)(10) or (16), this paragraph shall apply to such agency and each such agent or other person (except that, in the case of an agent, or any person including an agent described in subsection (l)(10) or (16), any report to the Secretary or other action with respect to the Secretary shall be made or taken through such agency). For purposes of applying this paragraph in any case to which subsection (m)(6) applies, the term "return information" includes related blood donor records (as defined in section 1141(h)(2) of the Social Security Act).

(5) REPORT ON PROCEDURES AND SAFEGUARDS.—After the close of each calendar year, the Secretary shall furnish to each committee described in subsection (f)(1) a report which describes the procedures and safeguards established and utilized by such agencies, bodies, or commissions, the Government Accountability Office, and the Congressional Budget Office for ensuring the confidentiality of returns and return information as required by this subsection. Such report shall also describe instances of deficiencies in, and failure to establish or utilize, such procedures.

(6) AUDIT OF PROCEDURES AND SAFEGUARDS.—

(A) AUDIT BY COMPTROLLER GENERAL.—The Comptroller General may audit the procedures and safeguards established by such agencies, bodies, or commissions and the Congressional Budget Office pursuant to this subsection to determine whether such safeguards and procedures meet the requirements of this subsection and ensure the confidentiality of returns and return information. The Comptroller General shall notify the Secretary before any such audit is conducted.

(B) RECORDS OF INSPECTION AND REPORTS BY THE COMPTROLLER GENERAL.—The Comptroller General shall—

(i) maintain a permanent system of standardized records and accountings of returns and return infor-

mation inspected by officers and employees of the Government Accountability Office under subsection (i)(8)(A)(ii) and shall, within 90 days after the close of each calendar year, furnish to the Secretary a report with respect to, or summary of, such records or accountings in such form and containing such information as the Secretary may prescribe, and

(ii) furnish an annual report to each committee described in subsection (f) and to the Secretary setting forth his findings with respect to any audit conducted pursuant to subparagraph (A).

The Secretary may disclose to the Joint Committee any report furnished to him under clause (i).

(7) ADMINISTRATIVE REVIEW.—The Secretary shall by regulations prescribe procedures which provide for administrative review of any determination under paragraph (4) that any agency, body, or commission described in subsection (d) has failed to meet the requirements of such paragraph.

(8) STATE LAW REQUIREMENTS.—

(A) SAFEGUARDS.—Notwithstanding any other provision of this section, no return or return information shall be disclosed after December 31, 1978, to any officer or employee of any State which requires a taxpayer to attach to, or include in, any State tax return a copy of any portion of his Federal return, or information reflected on such Federal return, unless such State adopts provisions of law which protect the confidentiality of the copy of the Federal return (or portion thereof) attached to, or the Federal return information reflected on, such State tax return.

(B) DISCLOSURE OF RETURNS OR RETURN INFORMATION IN STATE RETURNS.—Nothing in subparagraph (A) shall be construed to prohibit the disclosure by an officer or employee of any State of any copy of any portion of a Federal return or any information on a Federal return which is required to be attached or included in a State return to another officer or employee of such State (or political subdivision of such State) if such disclosure is specifically authorized by State law.

(q) REGULATIONS.—The Secretary is authorized to prescribe such other regulations as are necessary to carry out the provisions of this section.

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CHAPTER 68—ADDITIONS TO THE TAX, ADDITIONAL AMOUNTS, AND ASSESSABLE PENALTIES

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Subchapter B—Assessable Penalties

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PART I—GENERAL PROVISIONS

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SEC. 6676. ERRONEOUS CLAIM FOR REFUND OR CREDIT.

(a) **CIVIL PENALTY.**—If a claim for refund or credit with respect to income tax is made for an excessive amount, unless it is shown that the claim for such excessive amount is due to reasonable cause, the person making such claim shall be liable for a penalty in an amount equal to 20 percent (*25 percent in the case of a claim for refund or credit relating to the health insurance coverage credit under section 36C*) of the excessive amount.

(b) **EXCESSIVE AMOUNT.**—For purposes of this section, the term “excessive amount” means in the case of any person the amount by which the amount of the claim for refund or credit for any taxable year exceeds the amount of such claim allowable under this title for such taxable year.

(c) **NONECONOMIC SUBSTANCE TRANSACTIONS TREATED AS LACKING REASONABLE BASIS.**—For purposes of this section, any excessive amount which is attributable to any transaction described in section 6662(b)(6) shall not be treated as due to reasonable cause.

(d) **COORDINATION WITH OTHER PENALTIES.**—This section shall not apply to any portion of the excessive amount of a claim for refund or credit which is subject to a penalty imposed under part II of subchapter A of chapter 68.

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PART II—FAILURE TO COMPLY WITH CERTAIN INFORMATION REPORTING REQUIREMENTS

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SEC. 6724. WAIVER; DEFINITIONS AND SPECIAL RULES.

(a) **REASONABLE CAUSE WAIVER.**—No penalty shall be imposed under this part with respect to any failure if it is shown that such failure is due to reasonable cause and not to willful neglect.

(b) **PAYMENT OF PENALTY.**—Any penalty imposed by this part shall be paid on notice and demand by the Secretary and in the same manner as tax.

(c) **SPECIAL RULE FOR FAILURE TO MEET MAGNETIC MEDIA REQUIREMENTS.**—No penalty shall be imposed under section 6721 solely by reason of any failure to comply with the requirements of the regulations prescribed under section 6011(e)(2), except to the extent that such a failure occurs with respect to more than 250 information returns (more than 100 information returns in the case of a partnership having more than 100 partners) or with respect to a return described in section 6011(e)(4).

(d) **DEFINITIONS.**—For purposes of this part—

(1) **INFORMATION RETURN.**—The term “information return” means—

(A) any statement of the amount of payments to another person required by—

(i) section 6041(a) or (b) (relating to certain information at source),

(ii) section 6042(a)(1) (relating to payments of dividends),

- (iii) section 6044(a)(1) (relating to payments of patronage dividends),
 - (iv) section 6049(a) (relating to payments of interest),
 - (v) section 6050A(a) (relating to reporting requirements of certain fishing boat operators),
 - (vi) section 6050N(a) (relating to payments of royalties),
 - (vii) section 6051(d) (relating to information returns with respect to income tax withheld),
 - (viii) section 6050R (relating to returns relating to certain purchases of fish), or
 - (ix) section 110(d) (relating to qualified lessee construction allowances for short-term leases),
- (B) any return required by—
- (i) section 6041A(a) or (b) (relating to returns of direct sellers),
 - (ii) section 6043A(a) (relating to returns relating to taxable mergers and acquisitions),
 - (iii) section 6045(a) or (d) (relating to returns of brokers),
 - (iv) section 6045B(a) (relating to returns relating to actions affecting basis of specified securities),
 - (v) section 6050H(a) or (h)(1) (relating to mortgage interest received in trade or business from individuals),
 - (vi) section 6050I(a) or (g)(1) (relating to cash received in trade or business, etc.),
 - (vii) section 6050J(a) (relating to foreclosures and abandonments of security),
 - (viii) section 6050K(a) (relating to exchanges of certain partnership interests),
 - (ix) section 6050L(a) (relating to returns relating to certain dispositions of donated property),
 - (x) section 6050P (relating to returns relating to the cancellation of indebtedness by certain financial entities),
 - (xi) section 6050Q (relating to certain long-term care benefits),
 - (xii) section 6050S (relating to returns relating to payments for qualified tuition and related expenses),
 - (xiii) section 6050T (relating to returns relating to credit for health insurance costs of eligible individuals),
 - (xiv) section 6052(a) (relating to reporting payment of wages in the form of group-life insurance),
 - (xv) section 6050V (relating to returns relating to applicable insurance contracts in which certain exempt organizations hold interests),
 - (xvi) section 6053(c)(1) (relating to reporting with respect to certain tips),
 - (xvii) subsection (b) or (e) of section 1060 (relating to reporting requirements of transferors and transferees in certain asset acquisitions),

(xviii) section 4101(d) (relating to information reporting with respect to fuels taxes),

(xix) subparagraph (C) of section 338(h)(10) (relating to information required to be furnished to the Secretary in case of elective recognition of gain or loss),

(xx) section 264(f)(5)(A)(iv) (relating to reporting with respect to certain life insurance and annuity contracts), or

(xxi) section 6050U (relating to charges or payments for qualified long-term care insurance contracts under combined arrangements), and

(xxii) section 6039(a) (relating to returns required with respect to certain options),

(xxiii) section 6050W (relating to returns to payments made in settlement of payment card transactions),

(xxiv) section 6055 (relating to returns relating to information regarding health insurance coverage),
[or]

(xxv) section 6056 (relating to returns relating to certain employers required to report on health insurance coverage), or

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

(C) any statement of the amount of payments to another person required to be made to the Secretary under—

(i) section 408(i) (relating to reports with respect to individual retirement accounts or annuities), or

(ii) section 6047(d) (relating to reports by employers, plan administrators, etc.), and

(D) any statement required to be filed with the Secretary under section 6035.

Such term also includes any form, statement, or schedule required to be filed with the Secretary under chapter 4 or with respect to any amount from which tax was required to be deducted and withheld under chapter 3 (or from which tax would be required to be so deducted and withheld but for an exemption under this title or any treaty obligation of the United States).

(2) **PAYEE STATEMENT.**—The term “payee statement” means any statement required to be furnished under—

(A) section 6031(b) or (c), 6034A, or 6037(b) (relating to statements furnished by certain pass-thru entities),

(B) section 6039(b) (relating to information required in connection with certain options),

(C) section 6041(d) (relating to information at source),

(D) section 6041A(e) (relating to returns regarding payments of remuneration for services and direct sales),

(E) section 6042(c) (relating to returns regarding payments of dividends and corporate earnings and profits),

(F) subsections (b) and (d) of section 6043A (relating to returns relating to taxable mergers and acquisitions).

(G) section 6044(e) (relating to returns regarding payments of patronage dividends),

- (H) section 6045(b) or (d) (relating to returns of brokers),
- (I) section 6045A (relating to information required in connection with transfers of covered securities to brokers),
- (J) subsections (c) and (e) of section 6045B (relating to returns relating to actions affecting basis of specified securities),
- (K) section 6049(c) (relating to returns regarding payments of interest),
- (L) section 6050A(b) (relating to reporting requirements of certain fishing boat operators),
- (M) section 6050H(d) or (h)(2) relating to returns relating to mortgage interest received in trade or business from individuals),
- (N) section 6050I(e) or paragraph (4) or (5) of section 6050I(g) (relating to cash received in trade or business, etc.),
- (O) section 6050J(e) (relating to returns relating to foreclosures and abandonments of security),
- (P) section 6050K(b) (relating to returns relating to exchanges of certain partnership interests),
- (Q) section 6050L(c) (relating to returns relating to certain dispositions of donated property),
- (R) section 6050N(b) (relating to returns regarding payments of royalties),
- (S) section 6050P(d) (relating to returns relating to the cancellation of indebtedness by certain financial entities),
- (T) section 6050Q (relating to certain long-term care benefits),
- (U) section 6050R(c) (relating to returns relating to certain purchases of fish),
- (V) section 6051 (relating to receipts for employees),
- (W) section 6052(b) (relating to returns regarding payment of wages in the form of group-term life insurance),
- (X) section 6053(b) or (c) (relating to reports of tips),
- (Y) section 6048(b)(1)(B) (relating to foreign trust reporting requirements),
- (Z) section 408(i) (relating to reports with respect to individual retirement plans) to any person other than the Secretary with respect to the amount of payments made to such person,
- (AA) section 6047(d) (relating to reports by plan administrators) to any person other than the Secretary with respect to the amount of payments made to such person,
- (BB) section 6050S(d) (relating to returns relating to qualified tuition and related expenses),
- (CC) section 264(f)(5)(A)(iv) (relating to reporting with respect to certain life insurance and annuity contracts),
- (DD) section 6050T (relating to returns relating to credit for health insurance costs of eligible individuals)
- (EE) section 6050U (relating to charges or payments for qualified long-term care insurance contracts under combined arrangements),

(FF) section 6050W(f) (relating to returns relating to payments made in settlement of payment card transactions),

(GG) section 6055(c) (relating to statements relating to information regarding health insurance coverage),

(HH) section 6056(c) (relating to statements relating to certain employers required to report on health insurance coverage), **[or]**

(II) section 6035 (other than a statement described in paragraph (1)(D)) **[.].**

(JJ) section 6050X (relating to returns relating to health insurance coverage credit), or

(KK) section 7529(c)(3) (relating to documentation regarding other specified coverage).

Such term also includes any form, statement, or schedule required to be furnished to the recipient of any amount from which tax was required to be deducted and withheld under chapter 3 or 4 (or from which tax would be required to be so deducted and withheld but for an exemption under this title or any treaty obligation of the United States).

(3) SPECIFIED INFORMATION REPORTING REQUIREMENT.—The term “specified information reporting requirement” means—

(A) the notice required by section 6050K(c)(1) (relating to requirement that transferor notify partnership of exchange),

(B) any requirement contained in the regulations prescribed under section 6109 that a person—

(i) include his TIN on any return, statement, or other document (other than an information return or payee statement),

(ii) furnish his TIN to another person, or

(iii) include on any return, statement, or other document (other than an information return or payee statement) made with respect to another person the TIN of such person,

(C) any requirement contained in the regulations prescribed under section 215 that a person—

(i) furnish his TIN to another person, or

(ii) include on his return the TIN of another person, and

(D) any requirement under section 6109(h) that—

(i) a person include on his return the name, address, and TIN of another person, or

(ii) a person furnish his TIN to another person.

(4) REQUIRED FILING DATE.—The term “required filing date” means the date prescribed for filing an information return with the Secretary (determined with regard to any extension of time for filing).

(e) SPECIAL RULE FOR CERTAIN PARTNERSHIP RETURNS.—If any partnership return under section 6031(a) is required under section 6011(e) to be filed on magnetic media or in other machine-readable form, for purposes of this part, each schedule required to be included with such return with respect to each partner shall be treated as a separate information return.

(f) SPECIAL RULE FOR RETURNS OF EDUCATIONAL INSTITUTIONS RELATED TO HIGHER EDUCATION TUITION AND RELATED EXPENSES.—No penalty shall be imposed under section 6721 or 6722 solely by reason of failing to provide the TIN of an individual on a return or statement required by section 6050S(a)(1) if the eligible educational institution required to make such return contemporaneously makes a true and accurate certification under penalty of perjury (and in such form and manner as may be prescribed by the Secretary) that it has complied with standards promulgated by the Secretary for obtaining such individual's TIN.

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CHAPTER 77—MISCELLANEOUS PROVISIONS

Sec. 7501. Liability for taxes withheld or collected.

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Sec. 7529. Advance payment of health insurance coverage credit.

Sec. 7530. Excess health insurance coverage credit payable to health savings account.

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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 (hereafter in this section referred to as the “advance payment 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.*—

(1) *IN GENERAL.*—The advance payment program 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 (determined without regard to section 1412(f) of such Act) and each entity that is authorized to take any actions under the programs created under such sections (as so determined) shall, at the request of the Secretary, take such actions to the extent necessary to carry out this section.

(2) *APPLICATION TO OFF-EXCHANGE COVERAGE.*—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, the sections referred to in paragraph (1) shall be applied by treating references in such sections to an Exchange as references to the provider of such eligible health insurance (or, as the Secretary de-

termines appropriate, to the licensed agent or broker with respect to such insurance), except that the Secretary of Health and Human Services shall carry out the responsibilities of the Exchange under section 1411(e)(4) of the Patient Protection and Affordable Care Act (determined without regard to section 1412(f) of such Act) in the case of such insurance.

(3) **DOCUMENTATION REGARDING OTHER SPECIFIED COVERAGE.**—

(A) **IN GENERAL.**—The advance payment program shall provide that any individual applying to have payments made on their behalf under such program shall, if such individual (or any qualifying family member of such individual taken into account in determining the amount of the credit allowable under section 36C) is employed, submit a written statement from each employer of such individual or such qualifying family member stating whether such individual or qualifying family member (as the case may be) is eligible for other specified coverage in connection with such employment.

(B) **ISSUANCE OF STATEMENTS.**—An employer shall, at the request of any employee, provide the statement under subparagraph (A) at such time, and in such form and manner, as the Secretary may provide.

(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 subparagraph (A) of section 36C(b)(1) exceeds the amount described in subparagraph (B) 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(e)) 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 (c)(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 sections 7529 and 36C(i)(5)(B).

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PATIENT PROTECTION AND AFFORDABLE CARE ACT

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TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

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Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST- SHARING REDUCTIONS

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Subpart B—Eligibility Determinations

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SEC. 1412. ADVANCE DETERMINATION AND PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.

(a) **IN GENERAL.**—The Secretary, in consultation with the Secretary of the Treasury, shall establish a program under which—

(1) upon request of an Exchange, advance determinations are made under section 1411 with respect to the income eligibility of individuals enrolling in a qualified health plan in the individual market through the Exchange for the premium tax credit allowable under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402;

(2) the Secretary notifies—

(A) the Exchange and the Secretary of the Treasury of the advance determinations; and

(B) the Secretary of the Treasury of the name and employer identification number of each employer with respect to whom 1 or more employee of the employer were determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402 because—

(i) the employer did not provide minimum essential coverage; or

(ii) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) the Secretary of the Treasury makes advance payments of such credit or reductions to the issuers of the qualified health plans in order to reduce the premiums payable by individuals eligible for such credit.

(b) **ADVANCE DETERMINATIONS.**—

(1) **IN GENERAL.**—The Secretary shall provide under the program established under subsection (a) that advance determination of eligibility with respect to any individual shall be made—

(A) during the annual open enrollment period applicable to the individual (or such other enrollment period as may be specified by the Secretary); and

(B) on the basis of the individual's household income for the most recent taxable year for which the Secretary, after consultation with the Secretary of the Treasury, determines information is available.

(2) **CHANGES IN CIRCUMSTANCES.**—The Secretary shall provide procedures for making advance determinations on the basis of information other than that described in paragraph (1)(B) in cases where information included with an application form demonstrates substantial changes in income, changes in family size or other household circumstances, change in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility, including—

(A) allowing an individual claiming a decrease of 20 percent or more in income, or filing an application for unemployment benefits, to have eligibility for the credit determined on the basis of household income for a later period

or on the basis of the individual's estimate of such income for the taxable year; and

(B) the determination of household income in cases where the taxpayer was not required to file a return of tax imposed by this chapter for the second preceding taxable year.

(c) PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—

(1) IN GENERAL.—The Secretary shall notify the Secretary of the Treasury and the Exchange through which the individual is enrolling of the advance determination under section 1411.

(2) PREMIUM TAX CREDIT.—

(A) IN GENERAL.—The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986 to the issuer of a qualified health plan on a monthly basis (or such other periodic basis as the Secretary may provide).

(B) ISSUER RESPONSIBILITIES.—An issuer of a qualified health plan receiving an advance payment with respect to an individual enrolled in the plan shall—

(i) reduce the premium charged the insured for any period by the amount of the advance payment for the period;

(ii) notify the Exchange and the Secretary of such reduction;

(iii) include with each billing statement the amount by which the premium for the plan has been reduced by reason of the advance payment; and

(iv) in the case of any nonpayment of premiums by the insured—

(I) notify the Secretary of such nonpayment; and

(II) allow a 3-month grace period for nonpayment of premiums before discontinuing coverage.

(3) COST-SHARING REDUCTIONS.—The Secretary shall also notify the Secretary of the Treasury and the Exchange under paragraph (1) if an advance payment of the cost-sharing reductions under section 1402 is to be made to the issuer of any qualified health plan with respect to any individual enrolled in the plan. The Secretary of the Treasury shall make such advance payment at such time and in such amount as the Secretary specifies in the notice.

(d) NO FEDERAL PAYMENTS FOR INDIVIDUALS NOT LAWFULLY PRESENT.—Nothing in this subtitle or the amendments made by this subtitle allows Federal payments, credits, or cost-sharing reductions for individuals who are not lawfully present in the United States.

(e) STATE FLEXIBILITY.—Nothing in this subtitle or the amendments made by this subtitle shall be construed to prohibit a State from making payments to or on behalf of an individual for coverage under a qualified health plan offered through an Exchange that are in addition to any credits or cost-sharing reductions allowable to the individual under this subtitle and such amendments.

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

(g) *TERMINATION WITH RESPECT TO PREMIUM TAX CREDIT.*—Effective January 1, 2020, no provision of this section or section 1411 shall apply to the credit allowed under section 36B of the Internal Revenue Code of 1986 (or to the advance payment of, or determination of eligibility for, such credit or payment).

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TITLE IX—REVENUE PROVISIONS

Subtitle A—Revenue Offset Provisions

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SEC. 9008. IMPOSITION OF ANNUAL FEE ON BRANDED PRESCRIPTION PHARMACEUTICAL MANUFACTURERS AND IMPORTERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of manufacturing or importing branded prescription drugs shall pay to the Secretary of the Treasury not later than the annual payment date of each calendar year beginning after 2010 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term “annual payment date” means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to the applicable amount as—

(A) the covered entity’s branded prescription drug sales taken into account during the preceding calendar year, bear to

(B) the aggregate branded prescription drug sales of all covered entities taken into account during such preceding calendar year.

(2) SALES TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the branded prescription drug sales taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

Not more than \$5,000,000	0 percent
More than \$5,000,000 but not more than \$125,000,000.	10 percent
More than \$125,000,000 but not more than \$225,000,000.	40 percent

More than \$225,000,000 but not more than \$400,000,000. 75 percent
 More than \$400,000,000 100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary of the Treasury shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary of the Treasury shall determine such covered entity's branded prescription drug sales on the basis of reports submitted under subsection (g) and through the use of any other source of information available to the Secretary of the Treasury.

(4) APPLICABLE AMOUNT.—For purposes of paragraph (1), the applicable amount shall be determined in accordance with the following table:

Calendar year	Applicable amount
2011	\$2,500,000,000
2012	\$2,800,000,000
2013	\$2,800,000,000
2014	\$3,000,000,000
2015	\$3,000,000,000
2016	\$3,000,000,000
2017	\$4,000,000,000
2018	\$4,100,000,000
2019 and thereafter	\$2,800,000,000.

(c) TRANSFER OF FEES TO MEDICARE PART B TRUST FUND.—There is hereby appropriated to the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act an amount equal to the fees received by the Secretary of the Treasury under subsection (a).

(d) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term “covered entity” means any manufacturer or importer with gross receipts from branded prescription drug sales.

(2) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity.

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(3) JOINT AND SEVERAL LIABILITY.—If more than one person is liable for payment of the fee under subsection (a) with respect to a single covered entity by reason of the application of paragraph (2), all such persons shall be jointly and severally liable for payment of such fee.

(e) BRANDED PRESCRIPTION DRUG SALES.—For purposes of this section—

(1) IN GENERAL.—The term “branded prescription drug sales” means sales of branded prescription drugs to any specified government program or pursuant to coverage under any such program.

(2) BRANDED PRESCRIPTION DRUGS.—

(A) IN GENERAL.—The term “branded prescription drug” means—

(i) any prescription drug the application for which was submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)), or

(ii) any biological product the license for which was submitted under section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)).

(B) PRESCRIPTION DRUG.—For purposes of subparagraph (A)(i), the term “prescription drug” means any drug which is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)).

(3) EXCLUSION OF ORPHAN DRUG SALES.—The term “branded prescription drug sales” shall not include sales of any drug or biological product with respect to which a credit was allowed for any taxable year under section 45C of the Internal Revenue Code of 1986. The preceding sentence shall not apply with respect to any such drug or biological product after the date on which such drug or biological product is approved by the Food and Drug Administration for marketing for any indication other than the treatment of the rare disease or condition with respect to which such credit was allowed.

(4) SPECIFIED GOVERNMENT PROGRAM.—The term “specified government program” means—

(A) the Medicare Part D program under part D of title XVIII of the Social Security Act,

(B) the Medicare Part B program under part B of title XVIII of the Social Security Act,

(C) the Medicaid program under title XIX of the Social Security Act,

(D) any program under which branded prescription drugs are procured by the Department of Veterans Affairs,

(E) any program under which branded prescription drugs are procured by the Department of Defense, or

(F) the TRICARE retail pharmacy program under section 1074g of title 10, United States Code.

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code, shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—Not later than the date determined by the Secretary of the Treasury following the end of any calendar year, the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense shall report to the Secretary of the Treasury, in such manner as the Secretary of the Treasury prescribes, the total branded prescription

drug sales for each covered entity with respect to each specified government program under such Secretary's jurisdiction using the following methodology:

(1) **MEDICARE PART D PROGRAM.**—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part D program, the product of—

(A) the per-unit ingredient cost, as reported to the Secretary of Health and Human Services by prescription drug plans and Medicare Advantage prescription drug plans, minus any per-unit rebate, discount, or other price concession provided by the covered entity, as reported to the Secretary of Health and Human Services by the prescription drug plans and Medicare Advantage prescription drug plans, and

(B) the number of units of the branded prescription drug paid for under the Medicare Part D program.

(2) **MEDICARE PART B PROGRAM.**—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part B program under section 1862(a) of the Social Security Act, the product of—

(A) the per-unit average sales price (as defined in section 1847A(c) of the Social Security Act) or the per-unit Part B payment rate for a separately paid branded prescription drug without a reported average sales price, and

(B) the number of units of the branded prescription drug paid for under the Medicare Part B program.

The Centers for Medicare and Medicaid Services shall establish a process for determining the units and the allocated price for purposes of this section for those branded prescription drugs that are not separately payable or for which National Drug Codes are not reported.

(3) **MEDICAID PROGRAM.**—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered under the Medicaid program, the product of—

(A) the per-unit ingredient cost paid to pharmacies by States for the branded prescription drug dispensed to Medicaid beneficiaries, minus any per-unit rebate paid by the covered entity under section 1927 of the Social Security Act and any State supplemental rebate, and

(B) the number of units of the branded prescription drug paid for under the Medicaid program.

(4) **DEPARTMENT OF VETERANS AFFAIRS PROGRAMS.**—The Secretary of Veterans Affairs shall report, for each covered entity and for each branded prescription drug of the covered entity the total amount paid for each such branded prescription drug procured by the Department of Veterans Affairs for its beneficiaries.

(5) **DEPARTMENT OF DEFENSE PROGRAMS AND TRICARE.**—The Secretary of Defense shall report, for each covered entity and for each branded prescription drug of the covered entity, the sum of—

(A) the total amount paid for each such branded prescription drug procured by the Department of Defense for its beneficiaries, and

(B) for each such branded prescription drug dispensed under the TRICARE retail pharmacy program, the product of—

(i) the per-unit ingredient cost, minus any per-unit rebate paid by the covered entity, and

(ii) the number of units of the branded prescription drug dispensed under such program.

(h) SECRETARY.—For purposes of this section, the term “Secretary” includes the Secretary’s delegate.

(i) GUIDANCE.—The Secretary of the Treasury shall publish guidance necessary to carry out the purposes of this section.

(j) EFFECTIVE DATE.—This section shall apply to calendar years beginning after December 31, 2010.

(k) CONFORMING AMENDMENT.—Section 1841(a) of the Social Security Act is amended by inserting “or section 9008(c) of the Patient Protection and Affordable Care Act of 2009” after “this part”.

(l) TERMINATION.—*No fee shall be imposed under subsection (a)(1) with respect to any calendar year beginning after December 31, 2017.*

SEC. 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2013 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term “annual payment date” means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to the applicable amount as—

(A) the covered entity’s net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, bears to

(B) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year.

(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1)—

(A) IN GENERAL.—The net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

Not more than \$25,000,000	0 percent
More than \$25,000,000 but not more than \$50,000,000.	50 percent
More than \$50,000,000	100 percent.

(B) PARTIAL EXCLUSION FOR CERTAIN EXEMPT ACTIVITIES.—After the application of subparagraph (A), only 50 percent of the remaining net premiums written with respect to health insurance for any United States health risk that are attributable to the activities (other than activities of an unrelated trade or business as defined in section 513 of the Internal Revenue Code of 1986) of any covered entity qualifying under paragraph (3), (4), (26), or (29) of section 501(c) of such Code and exempt from tax under section 501(a) of such Code shall be taken into account.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's net premiums written with respect to any United States health risk on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term “covered entity” means any entity which provides health insurance for any United States health risk during the calendar year in which the fee under this section is due.

(2) EXCLUSION.—Such term does not include—

(A) any employer to the extent that such employer self-insures its employees' health risks,

(B) any governmental entity,

(C) any entity—

(i) which is incorporated as a nonprofit corporation under a State law,

(ii) no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in section 501(h) of the Internal Revenue Code of 1986), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office, and

(iii) more than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act, and

(D) any entity which is described in section 501(c)(9) of such Code and which is established by an entity (other

than by an employer or employers) for purposes of providing health care benefits.

(3) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity (or employer for purposes of paragraph (2)).

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

If any entity described in subparagraph (C) or (D) of paragraph (2) is treated as a covered entity by reason of the application of the preceding sentence, the net premiums written with respect to health insurance for any United States health risk of such entity shall not be taken into account for purposes of this section.

(4) JOINT AND SEVERAL LIABILITY.—If more than one person is liable for payment of the fee under subsection (a) with respect to a single covered entity by reason of the application of paragraph (3), all such persons shall be jointly and severally liable for payment of such fee.

(d) UNITED STATES HEALTH RISK.—For purposes of this section, the term “United States health risk” means the health risk of any individual who is—

(1) a United States citizen,

(2) a resident of the United States (within the meaning of section 7701(b)(1)(A) of the Internal Revenue Code of 1986), or

(3) located in the United States, with respect to the period such individual is so located.

(e) APPLICABLE AMOUNT.—For purposes of subsection (b)(1)—

(1) YEARS BEFORE 2019.—In the case of calendar years beginning before 2019, the applicable amount shall be determined in accordance with the following table:

Calendar year	Applicable amount
2014	\$8,000,000,000
2015	\$11,300,000,000
2016	\$11,300,000,000
2017	\$13,900,000,000
2018	\$14,300,000,000.

(2) YEARS AFTER 2018.—In the case of any calendar year beginning after 2018, the applicable amount shall be the applicable amount for the preceding calendar year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986) for such preceding calendar year.

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which

only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—

(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the covered entity's net premiums written with respect to health insurance for any United States health risk for such calendar year.

(2) PENALTY FOR FAILURE TO REPORT.—

(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report, an amount equal to—

(i) \$10,000, plus

(ii) the lesser of—

(I) an amount equal to \$1,000, multiplied by the number of days during which such failure continues, or

(II) the amount of the fee imposed by this section for which such report was required.

(B) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A)—

(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,

(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and

(iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.

(3) ACCURACY-RELATED PENALTY.—

(A) IN GENERAL.—In the case of any understatement of a covered entity's net premiums written with respect to health insurance for any United States health risk for any calendar year, there shall be paid by the covered entity making such understatement, an amount equal to the excess of—

(i) the amount of the covered entity's fee under this section for the calendar year the Secretary determines should have been paid in the absence of any such understatement, over

(ii) the amount of such fee the Secretary determined based on such understatement.

(B) UNDERSTATEMENT.—For purposes of this paragraph, an understatement of a covered entity's net premiums written with respect to health insurance for any United States health risk for any calendar year is the difference between the amount of such net premiums written as reported on the return filed by the covered entity under

paragraph (1) and the amount of such net premiums written that should have been reported on such return.

(C) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A) shall be subject to the provisions of subtitle F of the Internal Revenue Code of 1986 that apply to assessable penalties imposed under chapter 68 of such Code.

(4) TREATMENT OF INFORMATION.—Section 6103 of the Internal Revenue Code of 1986 shall not apply to any information reported under this subsection.

(h) ADDITIONAL DEFINITIONS.—For purposes of this section—

(1) SECRETARY.—The term “Secretary” means the Secretary of the Treasury or the Secretary’s delegate.

(2) UNITED STATES.—The term “United States” means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) HEALTH INSURANCE.—The term “health insurance” shall not include—

(A) any insurance coverage described in paragraph (1)(A) or (3) of section 9832(c) of the Internal Revenue Code of 1986,

(B) any insurance for long-term care, or

(C) any medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act).

(i) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section and shall prescribe such regulations as are necessary or appropriate to prevent avoidance of the purposes of this section, including inappropriate actions taken to qualify as an exempt entity under subsection (c)(2).

(j) EFFECTIVE DATE.—This section shall apply to calendar years—

(1) beginning after December 31, 2013, and ending before January 1, 2017, and

(2) beginning after December 31, 2017.

(k) TERMINATION.—*No fee shall be imposed under subsection (a)(1) with respect to any calendar year beginning after December 31, 2017.*

* * * * *

TITLE 31, UNITED STATES CODE

* * * * *

SUBTITLE II—THE BUDGET PROCESS

* * * * *

CHAPTER 13—APPROPRIATIONS

* * * * *

SUBCHAPTER II—TRUST FUNDS AND REFUNDS

* * * * *

§ 1324. Refund of internal revenue collections

(a) Necessary amounts are appropriated to the Secretary of the Treasury for refunding internal revenue collections as provided by law, including payment of—

- (1) claims for prior fiscal years; and
- (2) accounts arising under—
 - (A) “Allowance or drawback (Internal Revenue)”;
 - (B) “Redemption of stamps (Internal Revenue)”;
 - (C) “Refunding legacy taxes, Act of March 30, 1928”;
 - (D) “Repayment of taxes on distilled spirits destroyed by casualty”; and
 - (E) “Refunds and payments of processing and related taxes”.

(b) Disbursements may be made from the appropriation made by this section only for—

- (1) refunds to the limit of liability of an individual tax account; and
- (2) refunds due from credit provisions of the Internal Revenue Code of 1986 (26 U.S.C. 1 et seq.) enacted before January 1, 1978, or enacted by the Taxpayer Relief Act of 1997, or from section 25A, 35, 36, 36A, 36B, 36C, 168(k)(4)(F), 53(e), 54B(h), **[or 6431]** 6431, or 7530 of such Code, or due under section 3081(b)(2) of the Housing Assistance Tax Act of 2008.

* * * * *

VII. DISSENTING VIEWS

DISSENTING VIEWS ON RECOMMENDATION TO REPEAL THE NET INVESTMENT INCOME TAX, COMMITTEE PRINT 4

1. Donald Trump promised that “we’re going to have insurance for everybody . . . [but it will be] much less expensive and much better.” This bill reveals those promises for what they always were: empty campaign rhetoric.”— Families USA¹

2. “We cannot support the AHCA as drafted because of the expected decline in health insurance coverage and the potential harm it would cause to vulnerable patient populations.”—American Medical Association²

3. “Repeal-and-replace is a gigantic transfer of wealth from the lowest-income Americans to the highest-income Americans.”—Edward D. Kleinbard, former chief of staff for the Joint Committee on Taxation and professor, University of Southern California School of Law.³

The five reconciliation legislative recommendations considered by the Committee on Ways and Means (the “Committee”) and referred to the Committee on Budget (collectively, the Ways and Means reconciliation package or the “reconciliation package”) was a far-reaching attempt to undermine our health systems from Medicare to employer sponsored health insurance in order to give tax cuts to the wealthiest and corporations. After almost 18 hours of debate, the Committee mark-up ended with a party-line vote on the reconciliation package, which is likely to take health insurance away from millions of Americans. This reconciliation package, coupled with what was passed out of the Energy and Commerce Committee, would harm access to health care for middle-class Americans and undermine Medicare’s long-term viability while cutting taxes for corporations and the wealthiest Americans.

The Committee moved forward irresponsibly, without any official accounting about the estimated effect of the reconciliation package on health insurance coverage, out-of-pocket costs, or premium increases. While the Joint Committee on Taxation (JCT) estimated that the reconciliation package includes nearly \$600 billion worth of tax breaks, as of the mark-up, the Congressional Budget Office (CBO) was unable to provide estimates about the package’s effect on American families. Additionally the JCT score was incomplete as of the mark-up and did not provide an official accounting of all of the provisions considered by the Committee. Both the Ways and Means and Energy and Commerce Committees moved forward to pass recommendations out of each Committee without any sense

¹ <http://familiesusa.org/blog/2017/03/healthy-and-wealthy-benefit-under-house-republican-affordable-care-act-repeal-plan>

² <https://www.ama-assn.org/sites/default/files/media-browser/public/washington/ama-letter-on-ahca.pdf>

³ https://www.nytimes.com/2017/03/10/business/tax-cuts-affordable-care-act-repeal.html?_r=1.

from CBO of coverage losses due to the severe cuts to Medicaid, the repeal of the individual and employer-shared responsibility provisions of current law, or the changes in the tax credits available to help purchase health insurance on the individual market.

CBO provided the Committee an estimate of the effects after the reconciliation package was reported to the Committee on Budget from the Ways and Means and Energy and Commerce Committees. This estimate showed that 24 million Americans would lose coverage, with 14 million Americans losing coverage in the first year alone.

The Committee's reconciliation package provided generous tax cuts to the wealthiest, while reducing health insurance assistance for middle-class Americans. The tax breaks considered by the Committee are focused on the wealthy individuals and corporations, instead of middle-class Americans. About \$275 billion in tax breaks would benefit high-income earners; about 62% of the tax breaks would go to millionaires in 2020. Businesses and corporations are to receive nearly \$192 billion in tax cuts. These and other tax breaks add up to nearly \$600 billion in lost revenue.

Democrats objected strenuously to the Republican approach and instead believe the Committee should focus on policies that matter to middle-class Americans under the jurisdiction of this Committee, including financing long-term infrastructure, reforming the tax system to address income inequality, and further building on President Obama's record of job creation. Democrats believe that the reconciliation package will destabilize the health insurance market, which represents 18 percent of our gross domestic product.

The reconciliation package continues Republican efforts to undermine and destabilize the health insurance market. It undermines current law and the stability of both the individual and group health insurance markets by gutting individual and employer-shared responsibility provisions. The reconciliation package would reduce the uptake of the premium tax credits and the Medicaid expansion established in the Affordable Care Act (ACA), which have made health care affordable for millions of individuals. Reduced uptake of the Medicaid expansion and the tax credits disproportionately impacts low- and middle-income Americans and places them at risk for health insecurity and unexpected medical expenses. Based on independent estimates, roughly 24 million Americans would lose their insurance coverage because of this reconciliation package when taken together with the reconciliation recommendations passed by the Energy and Commerce Committee.⁴ Further, this reconciliation package reduces the life of the Medicare Trust Fund by three years by reducing \$170 billion from the Medicare Trust Fund, which puts Medicare at risk for 57 million seniors and individuals with disabilities.

Individual and employer-shared responsibility provisions are key to maintaining the robust and healthy risk pools that allow the ACA health insurance reforms to improve consumer protections while controlling health care costs. This is because well-functioning insurance markets rely on participation of both healthy and sick in-

⁴ <https://www.brookings.edu/blog/up-front/2017/03/09/expect-the-cbo-to-estimate-large-coverage-losses-from-the-gop-health-care-plan/>

dividuals to spread risk across the pool. The reconciliation package effectively would repeal the individual and employer-shared responsibility penalty, leading to premium increases of an estimated 20 percent in the individual market alone. In spite of President Trump and Congressional Republicans' efforts to sabotage the ACA, millions of Americans have enrolled in the health insurance Marketplaces, many using the available financial assistance, and millions more have enrolled in expanded Medicaid programs.

Despite promises made by President Trump, the reconciliation package would not cover more people or offer more affordable coverage with comparable benefits. Instead, this package leads to an estimated coverage loss of 24 million people while gutting benefits and consumer protections as a mechanism for affordability. When coupled with the legislation passed out of the Energy and Commerce Committee, the reconciliation package would return to a time when the market once again discriminates against those with pre-existing conditions and leaves those that might need medical care in the future without meaningful coverage. The reconciliation package provides for tax credits less generous than current law with no assistance with out-of-pocket expenses. Instead, the reconciliation package enshrines high deductible health plans that would increase out-of-pocket expenses. However, these plans do not address the underlying issues of access to quality services and the cost of care.

Since January of 2009, the Republicans voted to repeal or undermine the ACA more than 65 times. Democrats offered a number of amendments in Committee to point out serious flaws with the reconciliation package. For example, at the beginning of the mark up, Democrats asked Republicans to postpone mark up until CBO could provide a comprehensive report on costs, coverage losses, and premium effects of the reconciliation package.

In that regard, Congressman Lloyd Doggett (D-TX) offered a motion to postpone the markup for one week to allow time for review of the bill and the CBO estimate that was not available prior to or during the mark up. For over four decades, CBO has been recognized as the official referee of costs and effects of legislation passed in the House and Senate. Congress relies on CBO's non-partisan estimates to evaluate legislative proposals. Democrats were concerned that Republicans deliberately moved forward with the reconciliation package without a CBO score in an effort to conceal the harmful effects of the reconciliation package on nearly all Americans.

The contrast of this rushed process versus the lengthy and transparent process of enacting the ACA is striking. In 2009, House Committees posted a draft of the ACA legislation for review and comment a month before the mark-up process began, holding multiple hearings and providing the public with two preliminary CBO estimates on July 8th and July 14th. Democrats maintain that there is no reason to rush to mark-up this reconciliation package without a CBO score, or without a hearing to consider the implications of the package. Congressman Doggett's amendment was tabled on a party line vote.

The Committee print repeals the current tax on net investment income. The ACA imposed a 3.8% tax on net investment income at

a time when capital gains rates were near historical lows. Repeal of this tax, as well as the Medicare tax on high income earners (described below), would drain \$157.6 billion from the Treasury. The JCT found that by 2020, the repeal of the two tax provisions would save about \$15.9 billion a year for those with incomes of \$1 million or more. By 2026, the final year of the analysis, they would combine to save that group a little more than \$20 billion a year.⁵ With the 3.8 percent tax imposed by the ACA, the top capital gains rate stands at 23.8 percent for the wealthiest Americans, which is a lower rate than it was for most of the previous four decades.⁶

The Republican bill gives sixty percent of the tax cuts in this bill to millionaires, and each of the top 400 taxpayers would receive a \$7 million tax break.⁷ In contrast, the Republicans are slashing the social safety net, cutting \$370 billion from Medicaid, and increasing taxes to the middle-class families by rolling back the financial assistance to buy health insurance and cover out-of-pocket costs.

No doubt this provision benefits the richest Americans. President Trump's cabinet members and nominees have a combined net worth of \$13 billion.⁸ They likely would be significant beneficiaries of the tax giveaways under this bill. Those in the top 0.1 percent would each receive an average tax cut of about \$197,000 under the Republican plan.⁹ Those at the lowest income levels would get nothing—and lose health coverage.

Congressman Davis (D-IL) offered an amendment to require any taxpayer benefiting from the net investment income tax repeal for high-income earners to have a clean drug test each year prior to receiving this tax benefit, given that Republicans in the House recently voted (H.J. Res.42) to allow states to require drug testing for Americans who apply to receive unemployment benefits. Not surprisingly, this amendment was defeated along party lines.

RICHARD E. NEAL,
Ranking Member.

⁵ https://www.nytimes.com/2017/03/10/business/tax-cuts-affordable-care-act-repeal.html?_r=1

⁶ https://www.nytimes.com/2017/03/10/business/tax-cuts-affordable-care-act-repeal.html?_r=1

⁷ <http://www.cbpp.org/research/federal-tax/aca-repeal-would-lavish-medicare-tax-cuts-on-400-highest-income-households>

⁸ <https://www.bostonglobe.com/metro/2016/12/20/trump-cabinet-picks-far-are-worth-combined/XvAJmHCgkHhOI3ISxgiKvRM/story.html>

⁹ <http://www.taxpolicycenter.org/taxvox/repealing-affordable-care-act-would-cut-taxes-high-income-households-raise-taxes-many-others>

COMMITTEE PRINT

**Budget Reconciliation Legislative Recommendations
Relating to Repeal of Net Investment Income Tax**

**Subtitle _____—Repeal of Net Investment
Income Tax**

SEC. _1. REPEAL OF NET INVESTMENT INCOME TAX.

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

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

**AMENDMENT TO SECTION _15: REFUNDABLE TAX CREDIT FOR
HEALTH INSURANCE COVERAGE OFFERED BY REP. LINDA T.
SÁNCHEZ**

Sense of Congress that the Tanning Tax should not be repealed.

**AMENDMENTS CONSIDERED BY THE COMMITTEE ON
WAYS AND MEANS**

AMENDMENT

OFFERED BY MS. SÁNCHEZ OF CALIFORNIA

[Relating to Repeal of Tanning Tax]

Page 1, strike lines 3 through 8 and insert the following:

SEC. _1. SENSE OF CONGRESS REGARDING REPEAL OF TANNING TAX.

It is the sense of Congress that chapter 49 of the Internal Revenue Code of 1986 should not be repealed.

AMENDMENT TO AINS TO THE BUDGET RECONCILIATION LEGISLATIVE RECOMMENDATION RELATING TO REPEAL OF CERTAIN CONSUMER TAXES OFFERED BY REP. BLUMENAUER

The amendment would strike the repeal of the pharmaceutical company fee and transfer the revenues to the Federal Supplemental Medical Insurance trust fund, in order to help finance Medicare Part B and Part D.

AMENDMENT TO RECOMMENDATIONS RELATING TO REPEAL OF
CERTAIN CONSUMER TAXES

OFFERED BY MR. BLUMENAUER OF OREGON

Strike section _1 and insert the following:

**SEC. _1. APPLICATION OF CERTAIN REVENUES TOWARDS MEDICARE
PART B TRUST FUND.**

The Secretary of the Treasury shall provide for the transfer, annually to the credit of the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of the Social Security Act (42 U.S.C. 1395t), of an amount equivalent to the net annual revenues resulting from the application of section 9008 of the Patient Protection and Affordable Care Act (26 U.S.C. 4001 note prec.).

AMENDMENT TO THE AMENDMENT IN THE NATURE OF A SUBSTITUTE TO THE BUDGET RECONCILIATION LEGISLATIVE RECOMMENDATION RELATING TO REPEAL OF THE NET INVESTMENT INCOME TAX BY REP. DAVIS OF ILLINOIS

The amendment would require the taxpayer benefiting from the investment tax benefit to have a clean drug test annually prior to receipt.

AMENDMENT

OFFERED BY MR. DANNY K. DAVIS OF ILLINOIS

Repeal of Net Investment Income Tax

Add at the end the following new subsection:

(c) APPLICATION.—The amendment made by this section shall not apply to any taxpayer for a taxable year unless the taxpayer (and the spouse of the taxpayer in the case of a joint return) have a clean drug test during the 1-year period ending on the date of the filing of the return of tax for the taxable year.

AMENDMENT TO H.R. XXXX OFFERED BY RANKING MEMBER
RICHARD NEAL (MA)

The amendment would repeal Medicare tax increase.

AMENDMENT

OFFERED BY M____.

Strike section ____14 (relating to repeal of Medicare tax increase).

If consumers like the ACA they can keep it: Allows consumers the choice between the ACA's tax credits, or the American Health Care Act tax credits.

AMENDMENT

OFFERED BY MR. BLUMENAUER

At the end of the subtitle, add the following new section:

SEC. _____. ALLOWING CONSUMER CHOICE OF TAX CREDITS.

An individual may make an election under this section to apply section 36B of the Internal Revenue Code of 1986. If an individual so elects, the Secretary of the Treasury shall evaluate such individual's tax liability—

- (1) as if such section 36B were in effect; and
- (2) without regard to section 36C of such Code.

AMENDMENT TO [AMENDMENT IN THE NATURE OF A SUBSTITUTE TO
THE COMMITTEE PRINT RELATING TO REPEAL AND REPLACE OF
HEALTH-RELATED TAX POLICY] OFFERED BY REP. DELBENE

The amendment would fully repeal the excise tax on high-cost employee health plans ("Cadillac tax").

AMENDMENT

OFFERED BY MS. DELBENE, FOR HERSELF AND MS. SANCHEZ

S

Page 15, lines 9 through 10, strike “, and before January 1, 2025”.

SEWELL AMENDMENT #3 (PROTECTIONS FOR FARMERS)

This amendment would ensure that the American Health Care Act does not result in an increase in medical costs or taxes for socially or geographically disadvantaged farmers or farmers with disabilities.

AMENDMENT

OFFERED BY MS. SEWELL OF ALABAMA

Relating to Repeal and Replace of Health-Related Tax Policy Draft

Add at the end the following:

SEC. 19. INCREASE IN MEDICAL COSTS OR TAXES FOR SOCIALLY OR GEOGRAPHICALLY DISADVANTAGED FARMERS OR FARMERS WITH DISABILITIES.

Nothing in this subtitle (including any amendment made by this subtitle) shall be construed to increase medical costs or taxes for socially or geographically disadvantaged farmers or farmers with disabilities.

AMENDMENT TO H.R. _____, THE AMERICAN HEALTH CARE ACT
OFFERED BY REP. CHU

The amendment strikes the abortion restrictions in the bill.

AMENDMENT TO

OFFERED BY MS. JUDY CHU OF CALIFORNIA WITH MS. DELBENE AND
MS. SÁNCHEZ

[Repeal and Replace Health-Related Tax Policy]

Page 2, line 2, strike “, and” and all that follows through line 12 and insert a period.

Page 4, strike line 1 and all that follows through page 5, line 9.

Page 11, strike line 18 and all that follows through page 13, line 14.

Page 13, strike lines 19 through 23.

Page 24, line 25, insert “and” after the comma.

Page 25, strike lines 1 through 5 and redesignate the succeeding subparagraph accordingly.

Page 33, strike line 13 and all that follows through page 34, line 13.

AMENDMENT TO THE AMENDMENT IN THE NATURE OF A SUBSTITUTE
TO THE BUDGET RECONCILIATION LEGISLATIVE RECOMMENDA-
TIONS RELATING TO REPEAL AND REPLACE OF CERTAIN HEALTH-
RELATED TAX POLICY PROVISIONS BY REP. DAVIS OF ILLINOIS

The amendment would require that the credit apply only to health plans that include services from community providers, including rural providers, community health centers, and children's hospitals.

AMENDMENT TO

OFFERED BY MR. DAVIS OF ILLINOIS

**[Relating to Repeal and Replace of Health-Related Tax
Policy]**

In section 36C of the Internal Revenue Code of 1986, as inserted by section __15, at the end of subsection (f)(1), add the following flush matter:

“Such term does not include any health insurance coverage unless the coverage provides benefits for items and services furnished by or through essential community providers, including rural providers, community health centers, and children's hospitals, in a manner consistent with the criteria established under section 1311(c)(1)(C) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(1)(C)), as in effect on January 1, 2017.”.

AMENDMENT TO [AMENDMENT IN THE NATURE OF A SUBSTITUTE TO
THE COMMITTEE PRINT RELATING TO REPEAL AND REPLACE OF
HEALTH-RELATED TAX POLICY] OFFERED BY REP. DELBENE

The amendment would strike the underlying bill's repeal of the Small Business Tax Credit and insert reforms that make the tax credit accessible to more small businesses, available for three consecutive years (currently two), and easier to claim by eliminating burdensome requirements.

AMENDMENT TO RECOMMENDATIONS RELATING TO REPEAL AND
REPLACE

OFFERED BY MS. DELBENE OF WASHINGTON, FOR HERSELF, MR.
KIND, MR. HIGGINS AND MS. CHU

Strike section __04 and insert the following:

**SEC. __04. EXPANSION AND MODIFICATION OF CREDIT FOR EM-
PLOYEE HEALTH INSURANCE EXPENSES OF SMALL EM-
PLOYERS.**

(a) EXPANSION OF DEFINITION OF ELIGIBLE SMALL EMPLOYER.—
Subparagraph (A) of section 45R(d)(1) of the Internal Revenue Code
of 1986 is amended by striking “25” and inserting “50”.

(b) AMENDMENT TO PHASEOUT DETERMINATION.—Subsection (c) of section 45R of the Internal Revenue Code of 1986 is amended to read as follows:

“(c) PHASEOUT OF CREDIT AMOUNT BASED ON NUMBER OF EMPLOYEES AND AVERAGE WAGES.—The amount of the credit determined under subsection (b) (without regard to this subsection) shall be adjusted (but not below zero) by multiplying such amount by the product of—

“(1) the lesser of—

“(A) a fraction the numerator of which is the excess (if any) of 50 over the total number of full-time equivalent employees of the employer and the denominator of which is 30, and

“(B) 1, and

“(2) the lesser of—

“(A) a fraction—

“(i) the numerator of which is the excess (if any) of—

“(I) the dollar amount in effect under subsection (d)(3)(B) for the taxable year, multiplied by 3, over

“(II) the average annual wages of the employer for such taxable year, and

“(ii) the denominator of which is the dollar amount so in effect under subsection (d)(3)(B), multiplied by 2, and

“(B) 1.”.

(c) EXTENSION OF CREDIT PERIOD.—Paragraph (2) of section 45R(e) of the Internal Revenue Code of 1986 is amended by striking “2-consecutive-taxable year period” and all that follows and inserting “3-consecutive-taxable year period beginning with the first taxable year beginning after 2014 in which—

“(A) the employer (or any predecessor) offers one or more qualified health plans to its employees through an Exchange, and

“(B) the employer (or any predecessor) claims the credit under this section.”.

(d) AVERAGE ANNUAL WAGE LIMITATION.—Subparagraph (B) of section 45R(d)(3) of the Internal Revenue Code of 1986 is amended to read as follows:

“(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B) and subsection (c)(2), the dollar amount in effect under this paragraph is the amount equal to 110 percent of the poverty line (within the meaning of section 36B(d)(3)) for a family of 4.”.

(e) ELIMINATION OF UNIFORM PERCENTAGE CONTRIBUTION REQUIREMENT.—Paragraph (4) of section 45R(d) of the Internal Revenue Code of 1986 is amended by striking “a uniform percentage (not less than 50 percent)” and inserting “at least 50 percent”.

(f) ELIMINATION OF CAP RELATING TO AVERAGE LOCAL PREMIUMS.—Subsection (b) of section 45R of the Internal Revenue Code of 1986 is amended by striking “the lesser of” and all that follows and inserting “the aggregate amount of nonelective contributions the employer made on behalf of its employees during the taxable year under the arrangement described in subsection (d)(4) for

premiums for qualified health plans offered by the employer to its employees through an Exchange.”.

(g) CONFORMING AMENDMENT RELATING TO ANNUAL WAGE LIMITATION.—Subparagraph (B) of section 45R(d)(1) of the Internal Revenue Code of 1986 is amended by striking “twice” and inserting “three times”.

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2016.

AMENDMENT TO SECTION ____ 15: REFUNDABLE TAX CREDIT FOR
HEALTH INSURANCE COVERAGE OFFERED BY REP. LINDA SÁNCHEZ
Health plans cannot charge discriminate on the basis of gender.

AMENDMENT

OFFERED BY MS. SÁNCHEZ

**[Relating to Repeal and Replace of Health-Related Tax
Policy]**

In section 36C of the Internal Revenue Code of 1986, as inserted by section __ 15, at the end of subsection (f)(1), add the following flush matter:

“Such term does not include any health insurance coverage for which women are charged more than men.”.

AMENDMENT TO H.R. _____

OFFERED BY REP. JOHN LEWIS (GA)

This amendment would strike the entire section and replace it with a set of principles for any health reform legislation.

AMENDMENT

OFFERED BY MR. LEWIS OF GEORGIA

Strike section __ 01 and all that follows and insert the following:

SEC. __ 01. PRINCIPLES FOR HEALTH REFORM.

It is the sense of Congress that—

(1) affordable preventive health care is the right of every American and not a privilege of the wealthy,

(2) significant health care legislation should be developed through an open, transparent, and inclusive process, and

(3) any replacement of the Affordable Care Act should not put undue financial or health burdens on individuals and families who are elderly, middle and working class, low-income, or have chronic health conditions.

AMENDMENT BY CHAIRMAN KEVIN BRADY (TX-08) TO AMEND THE
CHAIRMAN'S AMENDMENT IN THE NATURE OF A SUBSTITUTE TO
THE COMMITTEE PRINT RELATING TO REPEAL AND REPLACE OF
HEALTH-RELATED TAX POLICY

This amendment would prohibit short-term limited duration insurance from being eligible coverage for purposes of the credit established under 36C.

AMENDMENT TO THE AMENDMENT IN THE NATURE OF A SUBSTITUTE
TO THE COMMITTEE PRINT RELATING TO REPEAL AND REPLACE OF
HEALTH-RELATED TAX POLICY

OFFERED BY MR. BRADY OF TEXAS

In section 36C(f)(1) of the Internal Revenue Code of 1986, as proposed to be inserted by section 15—

- (1) strike “and” at the end of subparagraph (D),
- (2) redesignate subparagraph (E) as subparagraph (F), and
- (3) insert after subparagraph (D) the following:
“ (E) such coverage does not consist of short-term limited duration insurance (as defined by the Secretary), and”.

VOTES OF THE COMMITTEE ON THE BUDGET

Clause 3(b) of House Rule XIII requires each committee report to accompany any bill or resolution of a public character to include the total number of votes cast for and against each roll call vote, on a motion to report and any amendments offered to the measure or matter, together with the names of those voting for and against.

Listed below are the actions taken in the Committee on the Budget of the House of Representatives on the American Health Care Act of 2017.

On March 16, 2017, the Committee met in open session, a quorum being present.

Mr. Rokita asked unanimous consent that the Chair be authorized, consistent with clause 4 of House Rule XVI, to declare a recess at any time during the Committee meeting.

There was no objection to the unanimous consent request.

The Committee adopted and ordered reported the American Health Care Act of 2017.

The Committee on the Budget took the following votes:

Mr. Rokita made a motion that the Committee report the bill with the recommendation that the bill do pass.

The motion was agreed to by a roll call vote of 19 ayes to 17 noes.

ROLLCALL VOTE NO. 1

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
BLACK (TN) (Chairman)	X			YARMUTH (KY) (Ranking)		X	
ROKITA (IN) (Vice Chairman)	X			LEE (CA)		X	
DIAZ-BALART (FL)	X			LUJAN GRISHAM (NM)		X	
COLE (OK)	X			MOULTON (MA)		X	
McCLINTOCK (CA)	X			JEFFRIES (NY)		X	
WOODALL (GA)	X			HIGGINS (NY)		X	
SANFORD (SC)		X		DeIBENE (WA)		X	
WOMACK (AR)	X			WASSERMAN SCHULTZ (FL)		X	
BRAT (VA)		X		BOYLE (PA)		X	
GROTHMAN (WI)	X			KHANNA (CA)		X	
PALMER (AL)		X		JAYAPAL (WA) (Vice Ranking)		X	
WESTERMAN (AR)	X			CARBAJAL (CA)		X	

ROLLCALL VOTE NO. 1—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
RENACCI (OH)	X			JACKSON LEE (TX)		X	
JOHNSON (OH)	X			SCHAKOWSKY (IL)		X	
SMITH (MO)	X						
LEWIS (MN)	X						
BERGMAN (MI)	X						
FASO (NY)	X						
SMUCKER (PA)	X						
GAETZ (FL)	X						
ARRINGTON (TX)	X						
FERGUSON (GA)	X						

Mr. Rokita made a motion that on the measure reported the staff be authorized to make any necessary technical and conforming corrections prior to filing the bill, such as inserting the short title of the bill, that the motion to reconsider be laid on the table, and that, pursuant to clause 1 of rule XXII, the Chair be authorized to offer motions to go to conference on the reported bill or any companion measure from the Senate.

The motion was agreed to without objection.

**Motions on the Rule for Consideration of the
American Health Care Act of 2017**

A Motion Offered by Mr. Boyle and Mr. Jeffries

1. Mr. Boyle and Mr. Jeffries moved that the Committee on the Budget direct its Chairman to request that the rule providing for consideration of the American Health Care Act make in order an amendment that would ensure the number of individuals without health insurance does not increase and that health care costs for individuals do not rise.

The motion was not agreed to by a roll call vote of 14 ayes and 20 noes.

ROLLCALL VOTE NO. 2

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
BLACK (TN) (Chairman)		X		YARMUTH (KY) (Ranking)	X		
ROKITA (IN) (Vice Chairman)		X		LEE (CA)	X		
DIAZ-BALART (FL)		X		LUJAN GRISHAM (NM)	X		
COLE (OK)		X		MOULTON (MA)	X		
McCLINTOCK (CA)		X		JEFFRIES (NY)	X		
WOODALL (GA)		X		HIGGINS (NY)	X		

ROLLCALL VOTE NO. 2—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
SANFORD (SC)		X		DeIBENE (WA)	X		
WOMACK (AR)		X		WASSERMAN SCHULTZ (FL)	X		
BRAT (VA)				BOYLE (PA)	X		
GROTHMAN (WI)		X		KHANNA (CA)	X		
PALMER (AL)		X		JAYAPAL (WA) (Vice Ranking)	X		
WESTERMAN (AR)		X		CARBAJAL (CA)	X		
RENACCI (OH)		X		JACKSON LEE (TX)	X		
JOHNSON (OH)		X		SCHAKOWSKY (IL)	X		
SMITH (MO)		X					
LEWIS (MN)		X					
BERGMAN (MI)		X					
FASO (NY)		X					
SMUCKER (PA)							
GAETZ (FL)		X					
ARRINGTON (TX)		X					
FERGUSON (GA)		X					

A Motion Offered by Mr. Higgins and Mr. Khanna

2. Mr. Higgins and Mr. Khanna moved that the Committee on the Budget direct its Chairman to request that the rule providing for consideration of the American Health Care Act make in order an amendment that strikes provisions in the bill relating to reductions in coverage or benefits, increased costs, and tax cuts.

The motion was not agreed to by a roll call vote of 14 ayes and 22 noes.

ROLLCALL VOTE NO. 3

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
BLACK (TN) (Chairman)		X		YARMUTH (KY) (Ranking)	X		
ROKITA (IN) (Vice Chairman)		X		LEE (CA)	X		
DIAZ-BALART (FL)		X		LUJAN GRISHAM (NM)	X		
COLE (OK)		X		MOULTON (MA)	X		
McCLINTOCK (CA)		X		JEFFRIES (NY)	X		
WOODALL (GA)		X		HIGGINS (NY)	X		
SANFORD (SC)		X		DeIBENE (WA)	X		

ROLLCALL VOTE NO. 3—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
WOMACK (AR)		X		WASSERMAN SCHULTZ (FL)	X		
BRAT (VA)		X		BOYLE (PA)	X		
GROTHMAN (WI)		X		KHANNA (CA)	X		
PALMER (AL)		X		JAYAPAL (WA) (Vice Ranking)	X		
WESTERMAN (AR)		X		CARBAJAL (CA)	X		
RENACCI (OH)		X		JACKSON LEE (TX)	X		
JOHNSON (OH)		X		SCHAKOWSKY (IL)	X		
SMITH (MO)		X					
LEWIS (MN)		X					
BERGMAN (MI)		X					
FASO (NY)		X					
SMUCKER (PA)		X					
GAETZ (FL)		X					
ARRINGTON (TX)		X					
FERGUSON (GA)		X					

A Motion Offered by Ms. Jayapal and Ms. Jackson Lee

3. Ms. Jayapal and Ms. Jackson Lee moved that the Committee on the Budget direct its Chairman to request that the rule providing for consideration of the American Health Care Act make in order an amendment that strikes language in the bill relating to ending Medicaid expansion, the Medicaid per capita cap, and the bill's tax cuts.

The motion was not agreed to by a roll call vote of 14 ayes and 22 noes.

ROLLCALL VOTE NO. 4

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
BLACK (TN) (Chairman)		X		YARMUTH (KY) (Ranking)	X		
ROKITA (IN) (Vice Chairman)		X		LEE (CA)	X		
DIAZ-BALART (FL)		X		LUJAN GRISHAM (NM)	X		
COLE (OK)		X		MOULTON (MA)	X		
McCLINTOCK (CA)		X		JEFFRIES (NY)	X		
WOODALL (GA)		X		HIGGINS (NY)	X		
SANFORD (SC)		X		DeIBENE (WA)	X		
WOMACK (AR)		X		WASSERMAN SCHULTZ (FL)	X		

ROLLCALL VOTE NO. 4—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
BRAT (VA)		X		BOYLE (PA)	X		
GROTHMAN (WI)		X		KHANNA (CA)	X		
PALMER (AL)		X		JAYAPAL (WA) (Vice Ranking)	X		
WESTERMAN (AR)		X		CARBAJAL (CA)	X		
RENACCI (OH)		X		JACKSON LEE (TX)	X		
JOHNSON (OH)		X		SCHAKOWSKY (IL)	X		
SMITH (MO)		X					
LEWIS (MN)		X					
BERGMAN (MI)		X					
FASO (NY)		X					
SMUCKER (PA)		X					
GAETZ (FL)		X					
ARRINGTON (TX)		X					
FERGUSON (GA)		X					

A Motion Offered by Mr. Moulton and Mr. Yarmuth

4. Mr. Moulton and Mr. Yarmuth moved that the Committee on the Budget direct its Chairman to request that the rule providing for consideration of the American Health Care Act make in order an amendment that strikes all provisions in the bill that lead to increased costs and reductions in coverage numbers in addition to tax cuts provided by the bill.

The motion was not agreed to by a roll call vote of 13 ayes and 21 noes.

ROLLCALL VOTE NO. 5

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
BLACK (TN) (Chairman)		X		YARMUTH (KY) (Ranking)	X		
ROKITA (IN) (Vice Chairman)		X		LEE (CA)	X		
DIAZ-BALART (FL)		X		LUJAN GRISHAM (NM)	X		
COLE (OK)		X		MOULTON (MA)	X		
McCLINTOCK (CA)		X		JEFFRIES (NY)	X		
WOODALL (GA)		X		HIGGINS (NY)	X		
SANFORD (SC)		X		DeIBENE (WA)	X		
WOMACK (AR)		X		WASSERMAN SCHULTZ (FL)	X		
BRAT (VA)				BOYLE (PA)			

ROLLCALL VOTE NO. 5—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
GROTHMAN (WI)		X		KHANNA (CA)	X		
PALMER (AL)		X		JAYAPAL (WA) (Vice Ranking)	X		
WESTERMAN (AR)		X		CARBAJAL (CA)	X		
RENACCI (OH)		X		JACKSON LEE (TX)	X		
JOHNSON (OH)		X		SCHAKOWSKY (IL)	X		
SMITH (MO)		X					
LEWIS (MN)		X					
BERGMAN (MI)		X					
FASO (NY)		X					
SMUCKER (PA)		X					
GAETZ (FL)		X					
ARRINGTON (TX)		X					
FERGUSON (GA)		X					

A Motion Offered by Ms. Lee and Ms. Schakowsky

5. Ms. Lee and Ms. Schakowsky moved that the Committee on the Budget direct its Chairman to request that the rule providing for consideration of the American Health Care Act make in order an amendment that would strike all provisions in the bill prohibiting mandatory funding for Planned Parenthood clinics for one year.

The motion was not agreed to by a roll call vote of 14 ayes and 21 noes.

ROLLCALL VOTE NO. 6

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
BLACK (TN) (Chairman)		X		YARMUTH (KY) (Ranking)	X		
ROKITA (IN) (Vice Chairman)		X		LEE (CA)	X		
DIAZ-BALART (FL)		X		LUJAN GRISHAM (NM)	X		
COLE (OK)		X		MOULTON (MA)	X		
McCLINTOCK (CA)		X		JEFFRIES (NY)	X		
WOODALL (GA)		X		HIGGINS (NY)	X		
SANFORD (SC)		X		DeBENE (WA)	X		
WOMACK (AR)		X		WASSERMAN SCHULTZ (FL)	X		
BRAT (VA)		X		BOYLE (PA)			
GROTHMAN (WI)		X		KHANNA (CA)	X		

ROLLCALL VOTE NO. 6—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
PALMER (AL)		X		JAYAPAL (WA) (Vice Ranking)	X		
WESTERMAN (AR)		X		CARBAJAL (CA)	X		
RENACCI (OH)		X		JACKSON LEE (TX)	X		
JOHNSON (OH)		X		SCHAKOWSKY (IL)	X		
SMITH (MO)		X					
LEWIS (MN)		X					
BERGMAN (MI)		X					
FASO (NY)	X						
SMUCKER (PA)		X					
GAETZ (FL)		X					
ARRINGTON (TX)		X					
FERGUSON (GA)		X					

A Motion Offered by Ms. DelBene and Ms. Wasserman Schultz

6. Ms. DelBene and Ms. Wasserman Schultz moved that the Committee on the Budget direct its Chairman to request that the rule providing for consideration of the American Health Care Act make in order an amendment that strikes language accelerating the insolvency of the Medicare Hospital Insurance Trust Fund by three years by repealing the additional Medicare tax on high-income earners.

The motion was not agreed to by a roll call vote of 13 ayes and 21 noes.

ROLLCALL VOTE NO. 7

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
BLACK (TN) (Chairman)		X		YARMUTH (KY) (Ranking)	X		
ROKITA (IN) (Vice Chairman)		X		LEE (CA)	X		
DIAZ-BALART (FL)		X		LUJAN GRISHAM (NM)	X		
COLE (OK)		X		MOULTON (MA)	X		
McCLINTOCK (CA)		X		JEFFRIES (NY)	X		
WOODALL (GA)		X		HIGGINS (NY)	X		
SANFORD (SC)		X		DelBENE (WA)	X		
WOMACK (AR)		X		WASSERMAN SCHULTZ (FL)	X		
BRAT (VA)				BOYLE (PA)			
GROTHMAN (WI)		X		KHANNA (CA)	X		

ROLLCALL VOTE NO. 7—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
PALMER (AL)		X		JAYAPAL (WA) (Vice Ranking)	X		
WESTERMAN (AR)		X		CARBAJAL (CA)	X		
RENACCI (OH)		X		JACKSON LEE (TX)	X		
JOHNSON (OH)		X		SCHAKOWSKY (IL)	X		
SMITH (MO)		X					
LEWIS (MN)		X					
BERGMAN (MI)		X					
FASO (NY)		X					
SMUCKER (PA)		X					
GAETZ (FL)		X					
ARRINGTON (TX)		X					
FERGUSON (GA)		X					

A Motion Offered by Ms. Lujan Grisham and Mr. Carbajal

7. Ms. Lujan Grisham and Mr. Carbajal moved that the Committee on the Budget direct its Chairman to request that the rule providing for consideration of the American Health Care Act make in order an amendment that would prevent the bill from taking effect until the Secretary of Health and Human Services determines that the bill would not decrease coverage, increase costs, or undermine parity of mental health and substance abuse services.

The motion was not agreed to by a roll call vote of 14 ayes and 22 noes.

ROLLCALL VOTE NO. 8

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
BLACK (TN) (Chairman)		X		YARMUTH (KY) (Ranking)	X		
ROKITA (IN) (Vice Chairman)		X		LEE (CA)	X		
DIAZ-BALART (FL)		X		LUJAN GRISHAM (NM)	X		
COLE (OK)		X		MOULTON (MA)	X		
McCLINTOCK (CA)		X		JEFFRIES (NY)	X		
WOODALL (GA)		X		HIGGINS (NY)	X		
SANFORD (SC)		X		DeBENE (WA)	X		
WOMACK (AR)		X		WASSERMAN SCHULTZ (FL)	X		
BRAT (VA)		X		BOYLE (PA)	X		
GROTHMAN (WI)		X		KHANNA (CA)	X		

ROLLCALL VOTE NO. 8—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
PALMER (AL)		X		JAYAPAL (WA) (Vice Ranking)	X		
WESTERMAN (AR)		X		CARBAJAL (CA)	X		
RENACCI (OH)		X		JACKSON LEE (TX)	X		
JOHNSON (OH)		X		SCHAKOWSKY (IL)	X		
SMITH (MO)		X					
LEWIS (MN)		X					
BERGMAN (MI)		X					
FASO (NY)		X					
SMUCKER (PA)		X					
GAETZ (FL)		X					
ARRINGTON (TX)		X					
FERGUSON (GA)		X					

A Motion Offered by Mr. Rokita

8. Mr. Rokita moved that the Committee on the Budget direct its Chairman to express the support of the Committee prior to the consideration of the rule for the American Health Care Act for state flexibility in the design of their Medicaid programs.

The motion was agreed to by a roll call vote of 21 ayes and 12 noes.

ROLLCALL VOTE NO. 9

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
BLACK (TN) (Chairman)	X			YARMUTH (KY) (Ranking)		X	
ROKITA (IN) (Vice Chairman)	X			LEE (CA)		X	
DIAZ-BALART (FL)	X			LUJAN GRISHAM (NM)		X	
COLE (OK)	X			MOULTON (MA)		X	
McCLINTOCK (CA)	X			JEFFRIES (NY)			
WOODALL (GA)	X			HIGGINS (NY)		X	
SANFORD (SC)	X			DeIBENE (WA)		X	
WOMACK (AR)	X			WASSERMAN SCHULTZ (FL)		X	
BRAT (VA)				BOYLE (PA)			
GROTHMAN (WI)	X			KHANNA (CA)		X	
PALMER (AL)	X			JAYAPAL (WA) (Vice Ranking)		X	
WESTERMAN (AR)	X			CARBAJAL (CA)		X	

ROLLCALL VOTE NO. 9—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
RENACCI (OH)	X			JACKSON LEE (TX)		X	
JOHNSON (OH)	X			SCHAKOWSKY (IL)		X	
SMITH (MO)	X						
LEWIS (MN)	X						
BERGMAN (MI)	X						
FASO (NY)	X						
SMUCKER (PA)	X						
GAETZ (FL)	X						
ARRINGTON (TX)	X						
FERGUSON (GA)	X						

A Motion Offered by Mr. Gaetz

9. Mr. Gaetz moved that the Committee on the Budget direct its Chairman to express the support of the Committee prior to the consideration of the rule for the American Health Care Act for policies that do not incentivize new Medicaid enrollment.

The motion was agreed to by a roll call vote of 22 ayes and 13 noes.

ROLLCALL VOTE NO. 10

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
BLACK (TN) (Chairman)	X			YARMUTH (KY) (Ranking)		X	
ROKITA (IN) (Vice Chairman)	X			LEE (CA)		X	
DIAZ-BALART (FL)	X			LUJAN GRISHAM (NM)		X	
COLE (OK)	X			MOULTON (MA)		X	
McCLINTOCK (CA)	X			JEFFRIES (NY)			
WOODALL (GA)	X			HIGGINS (NY)		X	
SANFORD (SC)	X			DeIBENE (WA)		X	
WOMACK (AR)	X			WASSERMAN SCHULTZ (FL)		X	
BRAT (VA)	X			BOYLE (PA)		X	
GROTHMAN (WI)	X			KHANNA (CA)		X	
PALMER (AL)	X			JAYAPAL (WA) (Vice Ranking)		X	
WESTERMAN (AR)	X			CARBAJAL (CA)		X	
RENACCI (OH)	X			JACKSON LEE (TX)		X	
JOHNSON (OH)	X			SCHAKOWSKY (IL)		X	

ROLLCALL VOTE NO. 10—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
SMITH (MO)	X						
LEWIS (MN)	X						
BERGMAN (MI)	X						
FASO (NY)	X						
SMUCKER (PA)	X						
GAETZ (FL)	X						
ARRINGTON (TX)	X						
FERGUSON (GA)	X						

A Motion Offered by Mr. Palmer

10. Mr. Palmer moved that the Committee on the Budget direct its Chairman to express the support of the Committee prior to the consideration of the rule for the American Health Care Act for encouraging able-bodied, working-age adults without dependents to meet a work requirement while enrolled in Medicaid.

The motion was agreed to by a roll call vote of 21 ayes and 13 noes.

ROLLCALL VOTE NO. 11

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
BLACK (TN) (Chairman)	X			YARMUTH (KY) (Ranking)		X	
ROKITA (IN) (Vice Chairman)	X			LEE (CA)		X	
DIAZ-BALART (FL)	X			LUJAN GRISHAM (NM)		X	
COLE (OK)	X			MOULTON (MA)		X	
McCLINTOCK (CA)	X			JEFFRIES (NY)			
WOODALL (GA)	X			HIGGINS (NY)		X	
SANFORD (SC)	X			DeIBENE (WA)		X	
WOMACK (AR)	X			WASSERMAN SCHULTZ (FL)		X	
BRAT (VA)	X			BOYLE (PA)		X	
GROTHMAN (WI)	X			KHANNA (CA)		X	
PALMER (AL)	X			JAYAPAL (WA) (Vice Ranking)		X	
WESTERMAN (AR)	X			CARBAJAL (CA)		X	
RENACCI (OH)	X			JACKSON LEE (TX)		X	
JOHNSON (OH)	X			SCHAKOWSKY (IL)		X	
SMITH (MO)	X						

ROLLCALL VOTE NO. 11—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
LEWIS (MN)	X						
BERGMAN (MI)	X						
FASO (NY)							
SMUCKER (PA)	X						
GAETZ (FL)	X						
ARRINGTON (TX)	X						
FERGUSON (GA)	X						

A Motion Offered by Mr. McClintock

11. Mr. McClintock moved that the Committee on the Budget direct its Chairman to express the support of the Committee prior to the consideration of the rule for the American Health Care Act for policies that ensure the personal tax credits are afforded to the population they are intended to serve.

The motion was agreed to by a roll call vote of 27 ayes and 8 noes.

ROLLCALL VOTE NO. 12

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
BLACK (TN) (Chairman)	X			YARMUTH (KY) (Ranking)	X		
ROKITA (IN) (Vice Chairman)	X			LEE (CA)		X	
DIAZ-BALART (FL)	X			LUJAN GRISHAM (NM)	X		
COLE (OK)	X			MOULTON (MA)	X		
McCLINTOCK (CA)	X			JEFFRIES (NY)			
WOODALL (GA)	X			HIGGINS (NY)		X	
SANFORD (SC)	X			DeIBENE (WA)		X	
WOMACK (AR)	X			WASSERMAN SCHULTZ (FL)		X	
BRAT (VA)	X			BOYLE (PA)	X		
GROTHMAN (WI)	X			KHANNA (CA)		X	
PALMER (AL)	X			JAYAPAL (WA) (Vice Ranking)		X	
WESTERMAN (AR)	X			CARBAJAL (CA)	X		
RENACCI (OH)	X			JACKSON LEE (TX)		X	
JOHNSON (OH)	X			SCHAKOWSKY (IL)		X	
SMITH (MO)	X						
LEWIS (MN)	X						

ROLLCALL VOTE NO. 12—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
BERGMAN (MI)	X						
FASO (NY)	X						
SMUCKER (PA)	X						
GAETZ (FL)	X						
ARRINGTON (TX)	X						
FERGUSON (GA)	X						

HOUSE REPORT REQUIREMENTS

Committee Oversight Findings

Clause 3(c)(1) of rule XIII of the Rules of the House of Representatives requires the report of a committee on a measure to contain oversight findings and recommendations required pursuant to Clause (2)(b)(1) of rule X. The Committee on the Budget has examined its activities over the past session and has determined that there are no specific oversight findings on the text of the reported bill.

Committee Cost Estimate

For purposes of Clauses 3(c)(2) and (3) of rule XIII of the Rules of the House of Representatives and Section 308(a)(1) of the Congressional Budget and Impoundment Control Act of 1974 (relating to estimates of new budget authority, new spending authority, new credit authority, or increased or decreased revenues or tax expenditures), the committee report incorporates the cost estimate prepared by the Director of the Congressional Budget Office pursuant to Sections 402 and 423 of the Congressional Budget and Impoundment Control Act of 1974. The required matter is included in the report language for each title of the legislative recommendations submitted by the appropriate authorizing committees and reported to the House by the Committee on the Budget.

Performance Goals and Objectives

Clause 3(c)(4) of rule XIII of the Rules of the House of Representatives requires the report of a committee on a measure to include a statement of general performance goals and objectives, including outcome-related goals and objectives, for which the measure authorizes funding. This bill is reported pursuant to Section 2002 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017. The goals and objectives of this bill are to reduce the deficit by at least \$2 billion over the 10-year period and clear the way for patient-centered health care reform that meets the principles set forth in the introduction of this report.

Constitutional Authority Statement

Clause 7(c)(1) of rule XII of the Rules of the House of Representatives requires each report of a committee on a public bill or public joint resolution contain a statement citing the specific powers granted to Congress in the Constitution to enact the law proposed by the bill or joint resolution. The Committee on the Budget finds the Constitutional authority for this legislation in Article I of the Constitution, Sections 5 and 8.

Changes in Existing Law Made by the Bill, as Reported

Clause 3(e) of rule XIII of the Rules of the House of Representatives requires each report of a committee on a bill or joint resolution contain the text of statutes that are proposed to be repealed and a comparative print of that part of the bill proposed to be amended whenever the bill repeals or amends any statute. The required matter is included in the report language for each title of the legislative recommendations submitted by the appropriate authorizing committees and reported to the House by the Committee on the Budget.

Federal Mandates Statement

Section 423 of the Congressional Budget and Impoundment Control Act of 1974 requires a statement of whether the provisions of the reported bill include unfunded mandates. The Congressional Budget Office has determined that the bill contains no intergovernmental or private sector mandates within the narrow definition of the Unfunded Mandates Reform Act of 1995. Any statements regarding unfunded mandates for the legislative recommendations submitted by each of the authorizing committees are included under the appropriate titles.

Advisory on Earmarks

In compliance with Clause 9 of rule XXI of the Rules of the House of Representatives, the bill does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in Clause 9(e), 9(f), or 9(g) of rule XXI of the Rules of the House of Representatives.

Duplication of Federal Programs

In compliance with Clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the reconciliation bill reported by the Committee on the Budget does not establish or reauthorize: (1) a program of the Federal Government known to be duplicative of another Federal program, (2) a program included in any report from the Government Accountability Office to Congress pursuant to Section 21 of Public Law 111-139, or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to Section 6104 of Title 31, United States Code.

Disclosure of Directed Rulemakings

Section 3(i) of H. Res. 5 requires committee reports on any bill or joint resolution to include a statement estimating the number of directed rulemakings required by the measure. This bill does not require any directed rulemakings.

VIEWS OF COMMITTEE MEMBERS

Clause 2(c) of rule XIII of the Rules of the House of Representatives requires each report by a committee on a public matter to include any additional, minority, supplemental, or dissenting views submitted pursuant to Clause 2(l) of rule XI by one or more members of the committee. In addition, this report includes views from members of committees submitting reconciliation recommendations pursuant to Section 2002 of S. Con. Res. 3 under the appropriate titles or subtitles, as the case may be, of this report. The minority views of members of the Committee on the Budget are as follows:

MINORITY VIEWS

The “Pay More for Less” Bill: A Massive Tax Giveaway to Billionaires and Corporations, Masquerading As Health Policy

After seven years railing against the Affordable Care Act, our Republican colleagues have finally produced a so-called plan. Drafted in secret, with no public hearings, it manages to unravel all of the gains the United States made under the law while doing nothing to address the problems that Members on both sides of the aisle agree need to be fixed.

This is not a health care bill at all. It is instead a classic expression of conservative ideology, taken to its illogical extreme. It provides a huge gift of \$600 billion in tax cuts that mostly benefit billionaires, millionaires, and corporations, paid for by taking critical health coverage and benefits away from millions of middle-class families, vulnerable children and families struggling to escape poverty, seniors, women, people in rural communities, and people with serious health problems or disabilities. This is Robin Hood in reverse, but far worse.

We now turn our focus to health care, since that supposedly is what this legislation is about. This bill does the exact opposite of everything President Trump and Congressional Republicans promised about providing better, cheaper health care for everybody. It will literally force millions of Americans to “Pay More for Less.”

Does this bill cover more people? No. In fact, the Congressional Budget Office (CBO) says 14 million people will lose coverage in 2018 as a result of this bill. By 2026, 24 million people will lose coverage, nearly doubling the ranks of the uninsured in that year. And the hardest hit will be Americans of modest incomes approaching retirement age. The CBO report states: “Although the agencies expect that the legislation would increase the number of uninsured broadly, the increase would be disproportionately larger among older people with lower income; in particular, people between 50 and 64 years old with income of less than 200 percent of the (federal poverty level) would make up a larger share of the uninsured.”

Does this bill lower premiums in the nongroup market? Not for people who need health coverage the most. Premiums go down for young people, but the older you are, the more this bill pushes up your premiums. By 2026, this bill will increase premiums for a 64-year-old by 20 to 25 percent.

Does the bill lower deductibles and other cost-sharing payments for care received? No. In fact, deductibles and cost-sharing payments will go up, and they will go up even more for people with pre-existing conditions. This bill allows insurers to offer less generous plans, which means transferring more financial risk onto people who need care. And it repeals the Affordable Care Act’s help with cost sharing for low-income enrollees, so their out-of-pocket costs go up even more.

Does the bill make any effort to address the underlying reasons health care is so expensive in this country, such as the outrageous prices charged for prescription drugs? No.

Does the bill make it easier for people to get the mental health care or addiction treatment they need, at a time the nation is facing an epidemic of opioid abuse? No. It makes it harder, by leaving 24 million additional people without coverage and by weakening requirements on insurers.

But does it give millionaires an average tax cut of \$50,000 every year? Yes, it does.

Once this piece of legislation became public, Republicans in Congress and the Administration began saying that the bill is not about making sure people have insurance coverage, it's about access to care. This position makes absolutely no sense. If you do not have health insurance, and you are not fortunate enough to be wealthy, then you do not have access to care, because you cannot afford it. Taking away health coverage makes it harder for people to get the care they need. It is astounding that Republican leaders in Congress and the Trump administration do not understand this basic fact about how regular American families live their lives.

It is no surprise that America's hospitals, doctors, nurses, the AARP, and both Democratic and Republican governors oppose this legislation. Other groups expressing concern about or outright opposition toward the bill include advocates for patients with cancer, diabetes, and other chronic diseases; public health workers; individuals with disabilities; advocates for women's health; religious organizations; Medicare beneficiaries; and many more. They understand that this bill will leave fewer people with coverage, and those who can still afford insurance will pay more for less.

How much more will people pay? This "Pay More For Less" plan raises costs substantially for Americans nearing retirement. The bill allows insurance companies to charge older enrollees higher premiums than allowed under current law. At the same time, the bill reduces the size of premium tax credits provided. Unlike those in the Affordable Care Act, the premium tax credits in this bill are not linked to the cost of coverage or what an individual or family can afford to pay. These changes hit older people with lower incomes the hardest. The net result: under this bill, by 2026, a 64-year-old with an income of \$26,500 will see his out-of-pocket payment toward his health insurance premium go from \$1,700 to \$14,600 – a \$12,900 hit on his pocketbook. He will have to give up half his annual income just for health insurance. This is not acceptable.

But the harm to older Americans in this bill does not stop there. The bill takes \$170 billion from the Medicare trust fund, shortening its life by three years and breaking President Trump's promise not to cut Medicare.

Even if people can afford the new premiums, they will be paying more for less because coverage will get skimpier. This bill is part of a larger Republican strategy to put insurance companies back in charge and eventually take away the Affordable Care Act's guarantees that insurance plans will cover services like maternity care, mental health, substance abuse services, and others. As direct out-of-pocket costs to consumers rise under this plan, we will once again return to a system where people are one serious illness or car accident away from bankruptcy.

Perhaps most disturbing is what this bill does to the more than 70 million low-income Americans who rely on Medicaid. Parents struggling to get by on poverty-level wages, seniors in nursing homes, children, people who are too disabled to work – Medicaid provides a critical health safety net to the most vulnerable people in our society. But this bill cuts \$880 billion from Medicaid over the next decade, sticking states with the bill. This will force states to either drop some people from Medicaid entirely or ration care for those who need access to comprehensive coverage the most. And it will force more families once again to rely on emergency-room care when they get sick, driving up health insurance premiums for everyone. The cuts get deeper with each passing year, reaching 25 percent of Medicaid spending in 2026. CBO estimates 5 million low-income Americans will lose Medicaid coverage in 2018, rising to 14 million ten years from now.

This is the most vivid example of the Robin-Hood-in-reverse principle that animates this entire piece of legislation. Republican proponents of this legislation try to sugarcoat these drastic changes by saying they want to “modernize and strengthen” Medicaid. In reality, this is Republican code for this bill’s real purpose and result: taking away critical Medicaid protections from the most vulnerable in our society, in order to pay for a tax cut of \$207,000 a year for the wealthiest 0.1 percent of Americans. To pay for a \$144 billion tax cut to insurance companies. To pay for a \$25 billion tax cut to the pharmaceutical industry. To pay for a special tax cut to subsidize the salaries of health insurance executives, who often make \$10 million or more. Public policy usually involves tradeoffs, but there is only one word to describe the tradeoff this bill makes: cruel.

Clearly, the “Pay More For Less” bill is not a health care plan. It is a “we don’t care” plan – because all this bill says to millions of hardworking Americans is that Congressional Republicans do not care about their health care needs.

The CBO report released earlier this week makes it clear that this bill will have disastrous consequences for millions of Americans who simply cannot afford for Congress to go down this path. The American people do not support this bill and did not ask for it. It is long past time for the Republican majority in this Congress to listen to the experts, the thousands of constituents in their districts benefiting from this law today, and the thousands more who have shown up to town halls across this country demanding that we improve the Affordable Care Act instead of dismantling it. We are ready to work with our Republican colleagues to ensure every family has access to quality, affordable health care. The American people deserve no less.

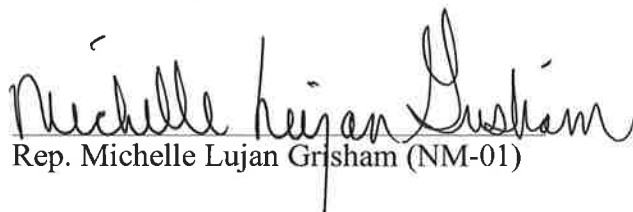
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Rep. Seth Moulton (MA-06)



Rep. Hakeem Jeffries (NY-08)



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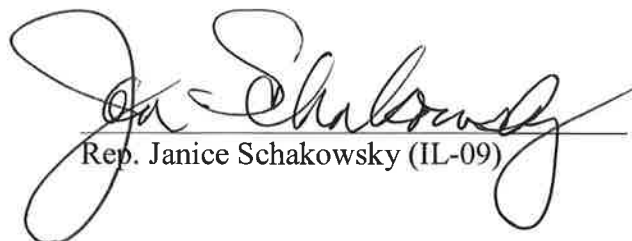
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