[DISCUSSION DRAFT]

115TH CONGRESS
1ST SESSION

H. R. _____

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

IN THE HOUSE OF REPRESENTATIVES

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

A BILL

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

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

SECTION 1. SHORT TITLE.

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

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

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

SEC. 103. REPEAL OF MEDICAID PROVISIONS.

The Social Security Act is amended—

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

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

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

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

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

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

(2) in subsection (z)(2)—

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

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

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

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

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

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

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

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

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

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

"(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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(I) is not made under section 1923;

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

"(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

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

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

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

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

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

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

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

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

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

"(f) SPECIAL PAYMENT RULES.—

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

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.

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

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

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

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

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

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

(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

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

"SEC. 2202. USE OF FUNDS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"SEC. 2711. ENCOURAGING CONTINUOUS HEALTH INSURANCE COVERAGE.

"(a) PENALTY APPLIED.—

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

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

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-

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

SEC. 112. OTHER MARKET REFORMS.

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

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

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

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

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

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

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

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

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

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

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

TITLE II—WAYS AND MEANS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Section 1412.

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

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

(d) EFFECTIVE DATES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 211. REPEAL OF TAX ON PRESCRIPTION MEDICATIONS.

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

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

SEC. 212. REPEAL OF MEDICAL DEVICE EXCISE TAX.

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

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

SEC. 216. REPEAL OF MEDICARE TAX INCREASE.

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

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

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

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

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

SEC. 217. REPEAL OF TANNING TAX.

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

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

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

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

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

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

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

"SEC. 36C. HEALTH INSURANCE COVERAGE.

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

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

"(2) LIMITATIONS.—

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

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

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

"(1) is covered by eligible health insurance,

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

"(3) is either—

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

"(B) is unsubsidized COBRA continuation coverage,

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

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

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

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

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

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

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

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

coverage unless such individual is enrolled in such coverage.

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

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

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

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

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

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

coverage under a health flexible spending arrangement.

"(h) SPECIAL RULES.—

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

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

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

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

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

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

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

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

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

"(i) such dollar amount, multiplied by

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

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

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

"(B) TERMS RELATED TO CPI.—

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

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

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

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

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

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

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

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

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

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

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

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

(c) INFORMATION REPORTING.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

group health plans for calendar year 2019, and

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

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

"(i) such amount, multiplied by—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.