and I urge my colleagues to join me in supporting this bill.

CUTTING TAXES FOR THE SUPERRICH AT THE EXPENSE OF EVERYONE ELSE

(Mrs. DEMINGS asked and was given permission to address the House for 1 minute.)

Mrs. DEMINGS. Mr. Speaker, I rise today to express my strong opposition to the Republican deal to cut taxes for the superrich at the expense of everyone else.

Apparently, Republicans believe the American people are just too distracted to recognize a con game when they see one. But make no mistake, the Republican plan is about giving tax breaks to the largest corporations and the superrich. It is not about the middle class or people who have to go to work every day. If working families had an opportunity to read the fine print, they would see that this bill has nothing to do with them.

Don't be fooled. The money needed to make this plan work has to come from somewhere. It will hurt working Americans and will cause our deficit to explode.

The strength of our country requires investing in people: so our children can have a better future, so their parents can have better jobs, so small businesses can thrive, and so seniors can retire with dignity. That is the America that we want, and that is the American promise we must keep.

ENSURING THE HEALTH OF OUR NATION'S CHILDREN

(Mr. BROWN of Maryland asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BROWN of Maryland. Mr. Speaker, 20 years ago, Congress enacted with strong, bipartisan support the Children's Health Insurance Program.

It fulfilled one of the highest responsibilities we have, which is to ensure the health and well-being of our Nation's children. Children without health insurance are less healthy, they go to the emergency room for chronic conditions like asthma and diabetes, and they do worse in school.

The program is extremely successful, increasing insurance coverage for children to 95 percent nationwide. Because of this, 138,000 Maryland children—and more than 8 million around the country—have received routine checkups, vaccinations, sick visits, prescriptions, dental and vision care, and emergency services.

We should not only reauthorize CHIP but work together to ensure every child in America has insurance.

Instead, the Republican Party is breaking the history of bipartisanship that CHIP has long enjoyed. Republicans are forcing us to choose between insuring kids and taking away coverage from 700,000 low-income Americans, raising premiums on seniors, and cutting the Prevention and Public Health Fund.

Mr. Speaker, let's stop playing politics with the healthcare of our children.

□ 0915

COMMUNITY HEALTH AND MEDICAL PROFESSIONALS IMPROVE OUR NATION ACT OF 2017

Mr. WALDEN. Mr. Speaker, pursuant to House Resolution 601, I call up the bill (H.R. 3922) to extend funding for certain public health programs, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. BYRNE). Pursuant to House Resolution 601, in lieu of the amendment in the nature of a substitute recommended by the Committee on Energy and Commerce printed in the bill, the amendment printed in part A of House Report 115–382, modified by the amendment printed in part B of the report, is adopted, and the bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

H.R. 3922

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 ''Continuing Community Health And Medical Professional Programs to Improve Our Nation, Increase National Gains, and Help Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2017'' or the ''CHAMPIONING HEALTHY KIDS Act''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

DIVISION A—CHAMPION ACT

SEC. 100. SHORT TITLE.

This division may be cited as the ''Community Health And Medical Professionals Improve Our Nation Act of 2017'' or the ''CHAMPION Act''.

TITLE I—EXTENSION OF PUBLIC HEALTH PROGRAMS

SEC. 101. EXTENSION FOR COMMUNITY HEALTH CENTERS, THE NATIONAL HEALTH SERVICE CORPS, AND TEACHING HEALTH CENTERS THAT OPERATE GME PROGRAMS.

(a) COMMUNITY HEALTH CENTERS FUNDING.—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 ''2017'' and inserting ''2019''.

(b) OTHER COMMUNITY HEALTH CENTERS PROVISIONS.—Section 330 of the Public Health Service Act (42 U.S.C. 254b) is amended—

(1) in subsection (b)(1)(A)(ii), by striking ''abuse'' and inserting ''use disorder'';

(2) in subsection (b)(2)(A), by striking ''abuse'' and inserting ''use disorder'';

(3) in subsection (c)—

(A) in paragraph (1), by striking subparagraphs (B) through (D);

(B) by striking ''(1) IN GENERAL'' and all that follows through ''The Secretary'' and inserting the following:

''(1) CENTERS.—The Secretary''; and

(C) in paragraph (1), as amended, by redesignating clauses (i) through (v) as subparagraphs (A) through (E) and moving the margin of each of such redesignated subparagraph 2 ems to the left;

(4) by striking subsection (d) and inserting the following:

''(d) IMPROVING QUALITY OF CARE.—

''(1) SUPPLEMENTAL AWARDS.—The Secretary may award supplemental grant funds to health centers funded under this section to implement evidence-based models for increasing access to high-quality primary care services, which may include models related to—

''(A) improving the delivery of care for individuals with multiple chronic conditions;

''(B) workforce configuration;

''(C) reducing the cost of care;

''(D) enhancing care coordination;

''(E) expanding the use of telehealth and technology-enabled collaborative learning and capacity building models;

''(F) care integration, including integration of behavioral health, mental health, or substance use disorder services; and

''(G) addressing emerging public health or substance use disorder issues to meet the

health needs of the population served by the health center.

''(2) SUSTAINABILITY.—In making supplemental awards under this subsection, the Secretary may consider whether the health center involved has submitted a plan for continuing the activities funded under this subsection after supplemental funding is expended.

''(3) SPECIAL CONSIDERATION.—The Secretary may give special consideration to applications for supplemental funding under this subsection that seek to address significant barriers to access to care in areas with a greater shortage of health care providers and health services relative to the national average.'';

(5) in subsection (e)(1)—

(A) in subparagraph (B)—

(i) by striking ''2 years'' and inserting ''1 year''; and

(ii) by adding at the end the following: ''The Secretary shall not make a grant under this paragraph unless the applicant provides assurances to the Secretary that within 120 days of receiving grant funding for the operation of the health center, the applicant will submit, for approval by the Secretary, an implementation plan to meet the requirements of subsection (k)(3). The Secretary may extend such 120-day period for achieving compliance upon a demonstration of good cause by the health center.''; and

(B) in subparagraph (C)—

(i) in the subparagraph heading, by striking ''AND PLANS'';

(ii) by striking ''or plan (as described in subparagraphs (B) and (C) of subsection (c)(1))'';

(iii) by striking ''or plan, including the purchase'' and inserting the following: ''including—

''(i) the purchase'';

(iv) by inserting '', which may include data and information systems'' after ''of equipment'';

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

(vi) by adding at the end the following:

''(ii) the provision of training and technical assistance; and

''(iii) other activities that—

''(I) reduce costs associated with the provision of health services;

''(II) improve access to, and availability of, health services provided to individuals served by the centers;

''(III) enhance the quality and coordination of health services; or

''(IV) improve the health status of communities.'';

(6) in subsection (e)(5)(B)—

(A) in the heading of subparagraph (B), by striking ''AND PLANS''; and

(B) by striking ''and subparagraphs (B) and (C) of subsection (c)(1) to a health center or to a network or plan'' and inserting ''to a health center or to a network'';

(7) in subsection (e), by adding at the end the following:

''(6) NEW ACCESS POINTS AND EXPANDED SERVICES.—

''(A) APPROVAL OF NEW ACCESS POINTS.—

''(i) IN GENERAL.—The Secretary may approve applications for grants under subparagraph (A) or (B) of paragraph (1) to establish new delivery sites.

''(ii) SPECIAL CONSIDERATION.—In carrying out clause (i), the Secretary may give special consideration to applicants that have demonstrated the new delivery site will be located within a sparsely populated area, or an area which has a level of unmet need that is higher relative to other applicants.

''(iii) CONSIDERATION OF APPLICATIONS.—In carrying out clause (i), the Secretary shall approve applications for grants in such a manner that the ratio of the medically underserved populations in rural areas which may be expected to use the services provided by the applicants involved to the medically underserved populations in urban areas which may be expected to use the services provided by the applicants is not less than two to three or greater than three to two.

''(iv) SERVICE AREA OVERLAP.—If in carrying out clause (i) the applicant proposes to serve an area that is currently served by another health center funded under this section, the Secretary may consider whether the award of funding to an additional health center in the area can be justified based on the unmet need for additional services within the catchment area.

''(B) APPROVAL OF EXPANDED SERVICE APPLICATIONS.—

''(i) IN GENERAL.—The Secretary may approve applications for grants under subparagraph (A) or (B) of paragraph (1) to expand the capacity of the applicant to provide required primary health services described in subsection (b)(1) or additional health services described in subsection (b)(2).

''(ii) PRIORITY EXPANSION PROJECTS.—In carrying out clause (i), the Secretary may give special consideration to expanded service applications that seek to address emerging public health or behavioral health, mental health, or substance abuse issues through increasing the availability of additional health services described in subsection (b)(2) in an area in which there are significant barriers to accessing care.

''(iii) CONSIDERATION OF APPLICATIONS.—In carrying out clause (i), the Secretary shall approve applications for grants in such a manner that the ratio of the medically underserved populations in rural areas which may be expected to use the services provided by the applicants involved to the medically underserved populations in urban areas which may be expected to use the services provided by such applicants is not less than two to three or greater than three to two.'';

(8) in subsection (h)—

(A) in paragraph (1), by striking ''and children and youth at risk of homelessness'' and inserting '', children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness''; and

(B) in paragraph (5)—

(i) by striking subparagraph (B);

(ii) by redesignating subparagraph (C) as subparagraph (B); and

(iii) in subparagraph (B) (as so redesignated)—

(I) in the subparagraph heading, by striking ''ABUSE'' and inserting ''USE DISORDER''; and

(II) by striking ''abuse'' and inserting ''use disorder'';

(9) in subsection (k)—

(A) in paragraph (2)—

(i) in the paragraph heading, by inserting ''UNMET'' before ''NEED'';

(ii) in the matter preceding subparagraph (A), by inserting ''or subsection (e)(6)'' after ''subsection (e)(1)'';

(iii) in subparagraph (A), by inserting ''unmet'' before ''need for health services'';

(iv) in subparagraph (B), by striking ''and'' at the end;

(v) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

(vi) by adding after subparagraph (C) the following:

''(D) in the case of an application for a grant pursuant to subsection (e)(6), a demonstration that the applicant has consulted with appropriate State and local government agencies, and health care providers regarding the need for the health services to be provided at the proposed delivery site.'';

(B) in paragraph (3)—

(i) in the matter preceding subparagraph (A), by inserting ''or subsection (e)(6)'' after ''subsection (e)(1)(B)'';

(ii) in subparagraph (B), by striking ''in the catchment area of the center'' and inserting '', including other health care providers that provide care within the catchment area, local hospitals, and specialty providers in the catchment area of the center, to provide access to services not available through the health center and to reduce the non-urgent use of hospital emergency departments'';

(iii) in subparagraph (H)(ii), by inserting ''who shall be directly employed by the center'' after ''approves the selection of a director for the center'';

(iv) in subparagraph (L), by striking ''and'' at the end;

(v) in subparagraph (M), by striking the period and inserting ''; and''; and

(vi) by inserting after subparagraph (M), the following:

''(N) the center has written policies and procedures in place to ensure the appropriate use of Federal funds in compliance with applicable Federal statutes, regulations, and the terms and conditions of the Federal award.''; and

(C) by striking paragraph (4);

(10) in subsection (l), by adding at the end the following: ''Funds expended to carry out activities under this subsection and operational support activities under subsection (m) shall not exceed 3 percent of the amount appropriated for this section for the fiscal year involved.'';

(11) in subsection (q)(4), by adding at the end the following: ''A waiver provided by the Secretary under this paragraph may not remain in effect for more than 1 year and may not be extended after such period. An entity may not receive more than one waiver under this paragraph in consecutive years.'';

(12) in subsection (r)(3)—

(A) by striking ''appropriate committees of Congress a report concerning the distribution of funds under this section'' and inserting the following: ''Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce of the House of Representatives, a report including, at a minimum—

''(A) the distribution of funds for carrying out this section'';

(B) by striking ''populations. Such report shall include an assessment'' and inserting the following: ''populations;

''(B) an assessment'';

(C) by striking ''and the rationale for any substantial changes in the distribution of funds.'' and inserting a semicolon; and

(D) by adding at the end the following:

''(C) the distribution of awards and funding for new or expanded services in each of rural areas and urban areas;

''(D) the distribution of awards and funding for establishing new access points, and the number of new access points created;

''(E) the amount of unexpended funding for loan guarantees and loan guarantee authority under title XVI;

''(F) the rationale for any substantial changes in the distribution of funds;

''(G) the rate of closures for health centers and access points;

''(H) the number and reason for any grants awarded pursuant to subsection (e)(1)(B); and

''(I) the number and reason for any waivers provided pursuant to subsection (q)(4).'';

(13) in subsection (r), by adding at the end the following new paragraph:

''(5) FUNDING FOR PARTICIPATION OF HEALTH CENTERS IN ALL OF US RESEARCH PROGRAM.—In addition to any amounts made available pursuant to paragraph (1) of this subsection, section 402A of this Act, or section 10503 of the Patient Protection and Affordable Care

Act, there is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, to the Secretary $25,000,000 for fiscal year 2018 to support the participation of health centers in the All of Us Research Program under the Precision Medicine Initiative under section 498E of this Act.''; and

(14) by striking subsection (s).

(c) 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 ''2017'' and inserting ''2019''.

(d) TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.—

(1) PAYMENTS.—Subsection (a) of section 340H of the Public Health Service Act (42 U.S.C. 256h) is amended to read as follows:

''(a) PAYMENTS.—

''(1) IN GENERAL.—Subject to subsection (h)(2), the Secretary shall make payments under this section for direct expenses and indirect expenses to qualified teaching health centers that are listed as sponsoring institutions by the relevant accrediting body for, as appropriate—

''(A) maintenance of existing approved graduate medical residency training programs;

''(B) expansion of existing approved graduate medical residency training programs; and

''(C) establishment of new approved graduate medical residency training programs.

''(2) PRIORITY.—In making payments pursuant to paragraph (1)(C), the Secretary shall give priority to qualified teaching health centers that—

''(A) serve a health professional shortage area with a designation in effect under section 332 or a medically underserved community (as defined in section 799B); or

''(B) are located in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act).''.

(2) FUNDING.—Subsection (g) of section 340H of the Public Health Service Act (42 U.S.C. 256h) is amended—

(A) by striking ''To carry out'' and inserting the following:

''(1) IN GENERAL.—To carry out'';

(B) by striking ''and $15,000,000 for the first quarter of fiscal year 2018'' and inserting ''and $126,500,000 for each of fiscal years 2018 and 2019, to remain available until expended''; and

(C) by adding at the end the following:

''(2) ADMINISTRATIVE EXPENSES.—Of the amount made available to carry out this section for any fiscal year, the Secretary may not use more than 5 percent of such amount for the expenses of administering this section.''.

(3) ANNUAL REPORTING.—Subsection (h)(1) of section 340H of the Public Health Service Act (42 U.S.C. 256h) is amended—

(A) by redesignating subparagraph (D) as subparagraph (H); and

(B) by inserting after subparagraph (C) the following:

''(D) The number of patients treated by residents described in paragraph (4).

''(E) The number of visits by patients treated by residents described in paragraph (4).

''(F) Of the number of residents described in paragraph (4) who completed their residency training at the end of such residency academic year, the number and percentage of such residents entering primary care practice (meaning any of the areas of practice listed in the definition of a primary care residency program in section 749A).

''(G) Of the number of residents described in paragraph (4) who completed their residency training at the end of such residency academic year, the number and percentage of such residents who entered practice at a health care facility—

''(i) primarily serving a health professional shortage area with a designation in effect under section 332 or a medically underserved community (as defined in section 799B); or

''(ii) located in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act).''.

(4) REPORT ON TRAINING COSTS.—Not later than March 31, 2019, the Secretary of Health and Human Services shall submit to the Congress a report on the direct graduate expenses of approved graduate medical residency training programs, and the indirect expenses associated with the additional costs of teaching residents, of qualified teaching health centers (as such terms are used or defined in section 340H of the Public Health Service Act (42 U.S.C. 256h)).

(5) DEFINITION.—Subsection (j) of section 340H of the Public Health Service Act (42 U.S.C. 256h) is amended—

(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively; and

(B) by inserting after paragraph (1) the following:

''(2) NEW APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'new approved graduate medical residency training program' means an approved graduate medical residency training program for which the sponsoring qualified teaching health center has not received a payment under this section for a previous fiscal year (other than pursuant to subsection (a)(1)(C)).''.

(6) TECHNICAL CORRECTION.—Subsection (f) of section 340H (42 U.S.C. 256h) is amended by striking ''hospital'' each place it appears and inserting ''teaching health center''.

(7) PAYMENTS FOR PREVIOUS FISCAL YEARS.—The provisions of section 340H of the Public Health Service Act (42 U.S.C. 256h), as in effect on the day before the date of enactment of this Act, shall continue to apply with respect to payments under such section for fiscal years before fiscal year 2018.

(e) APPLICATION.—Amounts appropriated pursuant to this section for fiscal year 2018 or 2019 are subject to the requirements contained in Public Law 115–31 for funds for programs authorized under sections 330 through 340 of the Public Health Service Act (42 U.S.C. 254b–256).

(f) CONFORMING AMENDMENTS.—Section 3014(h) of title 18, United States Code, is amended—

(1) in paragraph (1), by striking '', as amended by section 221 of the Medicare Access and CHIP Reauthorization Act of 2015,''; and

(2) in paragraph (4), by inserting ''and section 101(e) of the Community Health And Medical Professionals Improve Our Nation Act of 2017'' after ''section 221(c) of the Medicare Access and CHIP Reauthorization Act of 2015''.

SEC. 102. EXTENSION FOR SPECIAL DIABETES PROGRAMS.

(a) SPECIAL DIABETES PROGRAM FOR TYPE I DIABETES.—Section 330B(b)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)(C)) is amended by striking ''2017'' and inserting ''2019''.

(b) SPECIAL DIABETES PROGRAM FOR INDIANS.—Subparagraph (D) of section 330C(c)(2) of the Public Health Service Act (42 U.S.C. 254c–3(c)(2)) is amended to read as follows:

''(D) $150,000,000 for each of fiscal years 2018 and 2019.''.

SEC. 103. EXTENSION FOR FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

Section 501(c) of the Social Security Act (42 U.S.C. 701(c)) is amended—

(1) in paragraph (1)(A)—

(A) in clause (v), by striking ''and'' at the end;

(B) in clause (vi), by striking the period at the end and inserting ''; and''; and

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

''(vii) $6,000,000 for each of fiscal years 2018 and 2019.'';

(2) in paragraph (3)(C), by inserting before the period the following: '', and with respect to fiscal years 2018 and 2019, such centers shall also be developed in all territories and at least one such center shall be developed for Indian tribes''; and

(3) by amending paragraph (5) to read as follows:

''(5) For purposes of this subsection—

''(A) the term 'Indian tribe' has the meaning given such term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603);

''(B) the term 'State' means each of the 50 States and the District of Columbia; and

''(C) the term 'territory' means Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Northern Mariana Islands.''.

SEC. 104. YOUTH EMPOWERMENT PROGRAM; PERSONAL RESPONSIBILITY EDUCATION.

(a) YOUTH EMPOWERMENT PROGRAM.—

(1) IN GENERAL.—Section 510 of the Social Security Act (42 U.S.C. 710) is amended to read as follows:

''SEC. 510. YOUTH EMPOWERMENT PROGRAM.

''(a) IN GENERAL.—

''(1) ALLOTMENTS TO STATES.—For the purpose described in subsection (b), the Secretary shall, for each of fiscal years 2018 and 2019, allot to each State which has transmitted an application for the fiscal year under section 505(a) an amount equal to the product of—

''(A) the amount appropriated pursuant to subsection (e)(1) for the fiscal year, minus the amount reserved under subsection (e)(2) for the fiscal year; and

''(B) the proportion that the number of low-income children in the State bears to the total of such numbers of children for all the States.

''(2) OTHER ALLOTMENTS.—

''(A) OTHER ENTITIES.—For the purpose described in subsection (b), the Secretary shall, for each of fiscal years 2018 and 2019, for any State which has not transmitted an application for the fiscal year under section 505(a), allot to one or more entities in the State the amount that would have been allotted to the State under paragraph (1) if the State had submitted such an application.

''(B) PROCESS.—The Secretary shall select the recipients of allotments under subparagraph (A) by means of a competitive grant process under which—

''(i) not later than 30 days after the deadline for the State involved to submit an application for the fiscal year under section 505(a), the Secretary publishes a notice soliciting grant applications; and

''(ii) not later than 120 days after such deadline, all such applications must be submitted.

''(b) PURPOSE.—

''(1) IN GENERAL.—Except for research under paragraph (5) and information collection and reporting under paragraph (6), the purpose of an allotment under subsection (a) to a State (or to another entity in the State pursuant to subsection (a)(2)) is to enable the State or other entity to implement education exclusively on sexual risk avoidance (meaning voluntarily refraining from sexual activity).

''(2) REQUIRED COMPONENTS.—Education on sexual risk avoidance pursuant to an allotment under this section shall—

''(A) ensure that the unambiguous and primary emphasis and context for each topic

described in paragraph (3) is a message to youth that normalizes the optimal health behavior of avoiding nonmarital sexual activity;

''(B) be medically accurate and complete;

''(C) be age-appropriate; and

''(D) be based on adolescent learning and developmental theories for the age group receiving the education.

''(3) TOPICS.—Education on sexual risk avoidance pursuant to an allotment under this section shall address each of the following topics:

''(A) The holistic individual and societal benefits associated with personal responsibility, self-regulation, goal setting, healthy decisionmaking, and a focus on the future.

''(B) The advantage of refraining from nonmarital sexual activity in order to improve the future prospects and physical and emotional health of youth.

''(C) The increased likelihood of avoiding poverty when youth attain self-sufficiency and emotional maturity before engaging in sexual activity.

''(D) The foundational components of healthy relationships and their impact on the formation of healthy marriages and safe and stable families.

''(E) How other youth risk behaviors, such as drug and alcohol usage, increase the risk for teen sex.

''(F) How to resist and avoid, and receive help regarding, sexual coercion and dating violence, recognizing that even with consent teen sex remains a youth risk behavior.

''(4) CONTRACEPTION.—Education on sexual risk avoidance pursuant to an allotment under this section shall ensure that—

''(A) any information provided on contraception is medically accurate and ensures that students understand that contraception offers physical risk reduction, but not risk elimination; and

''(B) the education does not include demonstrations, simulations, or distribution of contraceptive devices.

''(5) RESEARCH.—

''(A) IN GENERAL.—A State or other entity receiving an allotment pursuant to subsection (a) may use up to 20 percent of such allotment to build the evidence base for sexual risk avoidance education by conducting or supporting research.

''(B) REQUIREMENTS.—Any research conducted or supported pursuant to subparagraph (A) shall be—

''(i) rigorous;

''(ii) evidence-based; and

''(iii) designed and conducted by independent researchers who have experience in conducting and publishing research in peer-reviewed outlets.

''(6) INFORMATION COLLECTION AND REPORTING.—A State or other entity receiving an allotment pursuant to subsection (a) shall, as specified by the Secretary—

''(A) collect information on the programs and activities funded through the allotment; and

''(B) submit reports to the Secretary on the data from such programs and activities.

''(c) NATIONAL EVALUATION.—

''(1) IN GENERAL.—The Secretary shall—

''(A) in consultation with appropriate State and local agencies, conduct one or more rigorous evaluations of the education funded through this section and associated data; and

''(B) submit a report to the Congress on the results of such evaluations, together with a summary of the information collected pursuant to subsection (b)(6).

''(2) CONSULTATION.—In conducting the evaluations required by paragraph (1), including the establishment of evaluation methodologies, the Secretary shall consult with relevant stakeholders.

''(d) APPLICABILITY OF CERTAIN PROVISIONS.—

''(1) Sections 503, 507, and 508 apply to allotments under subsection (a) to the same extent and in the same manner as such sections apply to allotments under section 502(c).

''(2) Sections 505 and 506 apply to allotments under subsection (a) to the extent determined by the Secretary to be appropriate.

''(e) FUNDING.—

''(1) IN GENERAL.—To carry out this section, there is appropriated, out of any money in the Treasury not otherwise appropriated, $75,000,000 for each of fiscal years 2018 and 2019.

''(2) RESERVATION.—The Secretary shall reserve, for each of fiscal years 2018 and 2019, not more than 20 percent of the amount appropriated pursuant to paragraph (1) for administering the program under this section, including the conducting of national evaluations and the provision of technical assistance to the recipients of allotments.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection takes effect on October 1, 2017.

(b) PERSONAL RESPONSIBILITY EDUCATION.—

(1) IN GENERAL.—Section 513 of the Social Security Act (42 U.S.C. 713) is amended—

(A) in subsection (a)(1)(A), by striking ''2017'' and inserting ''2019''; and

(B) in subsection (a)(4)—

(i) in subparagraph (A), by striking ''2017'' each place it appears and inserting ''2019''; and

(ii) in subparagraph (B)—

(I) in the subparagraph heading, by striking ''3-YEAR GRANTS'' and inserting ''COMPETITIVE PREP GRANTS''; and

(II) in clause (i), by striking ''solicit applications to award 3-year grants in each of fiscal years 2012 through 2017'' and inserting ''continue through fiscal year 2019 grants awarded for any of fiscal years 2015 through 2017'';

(C) in subsection (c)(1), by inserting after ''youth with HIV/AIDS,'' the following: ''victims of human trafficking,''; and

(D) in subsection (f), by striking ''2017'' and inserting ''2019''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on October 1, 2017.

TITLE II—OFFSETS

SEC. 201. PROVIDING FOR QUALIFIED HEALTH PLAN GRACE PERIOD REQUIREMENTS FOR ISSUER RECEIPT OF ADVANCE PAYMENTS OF COST-SHARING REDUCTIONS AND PREMIUM TAX CREDITS THAT ARE MORE CONSISTENT WITH STATE LAW GRACE PERIOD REQUIREMENTS.

(a) IN GENERAL.—Section 1412(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18082(c)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (B)(iv)(II), by striking ''a 3-month grace period'' and inserting ''a grace period specified in subparagraph (C)''; and

(B) by adding at the end the following new subparagraphs:

''(C) GRACE PERIOD SPECIFIED.—For purposes of subparagraph (B)(iv)(II), the grace period specified in this subparagraph is—

''(i) for plan years beginning before January 1, 2018, a 3-month grace period; and

''(ii) for plan years beginning on or after January 1, 2018—

''(I) in the case of an Exchange operating in a State that has a State law grace period in place, such State law grace period; and

''(II) in the case of an Exchange operating in a State that does not have a State law grace period in place, a 1-month grace period.

''(D) STATE LAW GRACE PERIOD.—For purposes of subparagraph (C), the term 'State law grace period' means, with respect to a State, a grace period for nonpayment of premiums before discontinuing coverage that is applicable under the State law to health insurance coverage offered in the individual market of the State.''; and

(2) in paragraph (3), by adding at the end the following new sentence: ''The requirements of paragraph (2)(B)(iv) apply to an issuer of a qualified health plan receiving an advanced payment under this paragraph in the same manner and to the same extent that such requirements apply to an issuer of a qualified health plan receiving an advanced payment under paragraph (2)(A).''.

(b) REPORT ON ALIGNING GRACE PERIODS FOR MEDICAID, MEDICARE, AND EXCHANGE PLANS.—Not later than two years after the date of full implementation of subsection (a), the Comptroller General of the United States shall submit to Congress a report on—

(1) the effects on consumers of aligning grace periods applied under the Medicaid program under title XIX of the Social Security Act, under the Medicare program under parts C and D of title XVIII of such Act, and under qualified health plans offered on an Exchange established under title I of the Patient Protection and Affordable Care Act, including the extent to which such an alignment of grace periods may help to avoid enrollment status confusion for individuals under such Medicaid program, Medicare program, and qualified health plans; and

(2) the extent to which such an alignment of grace periods may reduce fraud, waste, and abuse under the Medicaid program.

SEC. 202. PREVENTION AND PUBLIC HEALTH FUND.

Section 4002(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11(b)) is amended by striking paragraphs (3) through (8) and inserting the following new paragraphs:

''(3) for fiscal year 2018, $900,000,000;

''(4) for fiscal year 2019, $500,000,000;

''(5) for fiscal year 2020, $500,000,000;

''(6) for fiscal year 2021, $500,000,000;

''(7) for fiscal year 2022, $500,000,000;

''(8) for fiscal year 2023, $500,000,000;

''(9) for fiscal year 2024, $500,000,000;

''(10) for fiscal year 2025, $750,000,000;

''(11) for fiscal year 2026, $1,000,000,000; and

''(12) for fiscal year 2027 and each fiscal year thereafter, $2,000,000,000.''.

DIVISION B—HEALTHY KIDS ACT

SEC. 300. SHORT TITLE.

This division may be cited as the ''Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2017'' or the ''HEALTHY KIDS Act''.

TITLE I—CHIP EXTENSION AND OTHER MEDICAID AND CHIP PROVISIONS

SEC. 301. FIVE-YEAR FUNDING EXTENSION OF THE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) APPROPRIATION; TOTAL ALLOTMENT.—Section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) is amended—

(1) in paragraph (19), by striking ''and'';

(2) in paragraph (20), by striking the period at the end and inserting a semicolon; and

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

''(21) for fiscal year 2018, $21,500,000,000;

''(22) for fiscal year 2019, $22,600,000,000;

''(23) for fiscal year 2020, $23,700,000,000;

''(24) for fiscal year 2021, $24,800,000,000; and

''(25) for fiscal year 2022, for purposes of making 2 semi-annual allotments—

''(A) $2,850,000,000 for the period beginning on October 1, 2021, and ending on March 31, 2022; and

''(B) $2,850,000,000 for the period beginning on April 1, 2022, and ending on September 30, 2022.''.

(b) ALLOTMENTS.—

(1) IN GENERAL.—Section 2104(m) of the Social Security Act (42 U.S.C. 1397dd(m)) is amended—

(A) in paragraph (2)—

(i) in the heading, by striking ''THROUGH 2016'' and inserting ''THROUGH 2022''; and

(ii) in subparagraph (B)—

(I) in the matter preceding clause (i), by striking ''(19)'' and inserting ''(24)'';

(II) in clause (ii), in the matter preceding subclause (I), by inserting ''(other than fiscal year 2022)'' after ''even-numbered fiscal year''; and

(III) in clause (ii)(I), by inserting ''(or, in the case of fiscal year 2018, under paragraph (4))'' after ''clause (i)'';

(B) in paragraph (5)—

(i) by striking ''or (4)'' and inserting ''(4), or (10)''; and

(ii) by striking ''or 2017'' and inserting '', 2017, or 2022'';

(C) in paragraph (7)—

(i) in subparagraph (A), by striking ''2017'' and inserting ''2022'';

(ii) in subparagraph (B), in the matter preceding clause (i), by inserting ''(or, in the case of fiscal year 2018, by not later than the date that is 60 days after the date of the enactment of the HEALTHY KIDS Act)'' after ''before the August 31 preceding the beginning of the fiscal year''; and

(iii) in the matter following subparagraph (B), by striking ''or fiscal year 2016'' and inserting ''fiscal year 2016, fiscal year 2018, fiscal year 2020, or fiscal year 2022'';

(D) in paragraph (9)—

(i) in the heading, by striking ''FISCAL YEARS 2015 AND 2017'' and inserting ''CERTAIN FISCAL YEARS'';

(ii) by striking ''or (4)'' and inserting '', (4), or (10)''; and

(iii) by striking ''or fiscal year 2017'' and inserting '', 2017, or 2022''; and

(E) by adding at the end the following new paragraph:

''(10) FOR FISCAL YEAR 2022.—

''(A) FIRST HALF.—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (A) of paragraph (25) of subsection (a) for the semi-annual period described in such subparagraph, increased by the amount of the appropriation for such period under section 301(b)(3) of the HEALTHY KIDS Act, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the first half ratio (described in subparagraph (D)) of the amount described in subparagraph (C).

''(B) SECOND HALF.—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (B) of paragraph (25) of subsection (a) for the semi-annual period described in such subparagraph, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the amount made available under such subparagraph, multiplied by the ratio of—

''(i) the amount of the allotment to such State under subparagraph (A); to

''(ii) the total of the amount of all of the allotments made available under such subparagraph.

''(C) FULL YEAR AMOUNT BASED ON GROWTH FACTOR UPDATED AMOUNT.—The amount described in this subparagraph for a State is equal to the sum of—

''(i) the amount of the State allotment for fiscal year 2021 determined under paragraph (2)(B)(i); and

''(ii) the amount of any payments made to the State under subsection (n) for fiscal year 2021, multiplied by the allotment increase factor under paragraph (6) for fiscal year 2022.

''(D) FIRST HALF RATIO.—The first half ratio described in this subparagraph is the ratio of—

''(i) the sum of—

''(I) the amount made available under subsection (a)(25)(A); and

''(II) the amount of the appropriation for such period under section 301(b)(3) of the HEALTHY KIDS Act; to

''(ii) the sum of—

''(I) the amount described in clause (i); and

''(II) the amount made available under subsection (a)(25)(B).''.

(2) TECHNICAL AMENDMENT.—Section 2104(m)(2)(A) of such Act (42 U.S.C. 1397dd(m)(2)(A)) is amended by striking ''the allotment increase factor under paragraph (5)'' each place it appears and inserting ''the allotment increase factor under paragraph (6)''.

(3) ONE-TIME APPROPRIATION FOR FISCAL YEAR 2022.—There is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated, $20,200,000,000 to accompany the allotment made for the period beginning on October 1, 2021, and ending on March 31, 2022, under paragraph (25)(A) of section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) (as added by subsection (a)(3)), to remain available until expended. Such amount shall be used to provide allotments to States under paragraph (10) of section 2104(m) of such Act (as added by subsection (b)(1)(E)) for the first 6 months of fiscal year 2022 in the same manner as allotments are provided under subsection (a)(25)(A) of such section 2104 and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(25)(A).

(c) EXTENSION OF THE CHILD ENROLLMENT CONTINGENCY FUND.—Section 2104(n) of the Social Security Act (42 U.S.C. 1397dd(n)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (A)(ii)—

(i) by striking ''2010, 2011, 2012, 2013, 2014, and 2016'' and inserting ''2010 through 2014, 2016, and 2018 through 2021''; and

(ii) by striking ''fiscal year 2015 and fiscal year 2017'' and inserting ''fiscal years 2015, 2017, and 2022''; and

(B) in subparagraph (B)—

(i) by striking ''2010, 2011, 2012, 2013, 2014, and 2016'' and inserting ''2010 through 2014, 2016, and 2018 through 2021''; and

(ii) by striking ''fiscal year 2015 and fiscal year 2017'' and inserting ''fiscal years 2015, 2017, and 2022''; and

(2) in paragraph (3)(A), in the matter preceding clause (i), by striking ''or a semi-annual allotment period for fiscal year 2015 or 2017'' and inserting ''or in any of fiscal years 2018 through 2021 (or a semi-annual allotment period for fiscal year 2015, 2017, or 2022)''.

(d) EXTENSION OF QUALIFYING STATES OPTION.—Section 2105(g)(4) of the Social Security Act (42 U.S.C. 1397ee(g)(4)) is amended—

(1) in the heading, by striking ''THROUGH 2017'' and inserting ''THROUGH 2022''; and

(2) in subparagraph (A), by striking ''2017'' and inserting ''2022''.

(e) EXTENSION OF EXPRESS LANE ELIGIBILITY OPTION.—Section 1902(e)(13)(I) of the Social Security Act (42 U.S.C. 1396a(e)(13)(I)) is amended by striking ''2017'' and inserting ''2022''.

(f) ASSURANCE OF AFFORDABILITY STANDARD FOR CHILDREN AND FAMILIES.—

(1) IN GENERAL.—Section 2105(d)(3) of the Social Security Act (42 U.S.C. 1397ee(d)(3)) is amended—

(A) in the paragraph heading, by striking ''UNTIL OCTOBER 1, 2019'' and inserting ''THROUGH SEPTEMBER 30, 2022''; and

(B) in subparagraph (A), in the matter preceding clause (i)—

(i) by striking ''2019'' and inserting ''2022''; and

(ii) by striking ''The preceding sentence shall not be construed as preventing a State during such period'' and inserting ''During the period that begins on October 1, 2019, and ends on September 30, 2022, the preceding sentence shall only apply with respect to children in families whose income does not exceed 300 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved. The preceding sentences shall not be construed as preventing a State during any such periods''.

(2) CONFORMING AMENDMENTS.—Section 1902(gg)(2) of the Social Security Act (42 U.S.C. 1396a(gg)(2)) is amended—

(A) in the paragraph heading, by striking ''UNTIL OCTOBER 1, 2019'' and inserting ''THROUGH SEPTEMBER 30, 2022''; and

(B) by striking ''September 30, 2019,'' and inserting ''September 30, 2022 (but during the period that begins on October 1, 2019, and ends on September 30, 2022, only with respect to children in families whose income does not exceed 300 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved)''.

(g) CHIP LOOK-ALIKE PLANS.—

(1) BLENDING RISK POOLS.—Section 2107 of the Social Security Act (42 U.S.C. 1397gg) is amended by adding at the end the following:

''(g) USE OF BLENDED RISK POOLS.—

''(1) IN GENERAL.—Nothing in this title (or any other provision of Federal law) shall be construed as preventing a State from considering children enrolled in a qualified CHIP look-alike program and children enrolled in a State child health plan under this title (or a waiver of such plan) as members of a single risk pool.

''(2) QUALIFIED CHIP LOOK-ALIKE PROGRAM.—In this subsection, the term 'qualified CHIP look-alike program' means a State program—

''(A) under which children who are under the age of 19 and are not eligible to receive medical assistance under title XIX or child health assistance under this title may purchase coverage through the State that provides benefits that are at least identical to the benefits provided under the State child health plan under this title (or a waiver of such plan); and

''(B) that is funded exclusively through non-Federal funds, including funds received by the State in the form of premiums for the purchase of such coverage.''.

(2) COVERAGE RULE.—

(A) IN GENERAL.—Section 5000A(f)(1) of the Internal Revenue Code of 1986 is amended in subparagraph (A)(iii), by inserting ''or under a qualified CHIP look-alike program (as defined in section 2107(g) of the Social Security Act)'' before the comma at the end.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply with respect to taxable years beginning after December 31, 2017.

SEC. 302. EXTENSION OF CERTAIN PROGRAMS AND DEMONSTRATION PROJECTS.

(a) CHILDHOOD OBESITY DEMONSTRATION PROJECT.—Section 1139A(e)(8) of the Social Security Act (42 U.S.C. 1320b–9a(e)(8)) is amended—

(1) by striking ''and $10,000,000'' and inserting '', $10,000,000''; and

(2) by inserting after ''2017'' the following: '', and $25,000,000 for the period of fiscal years 2018 through 2022''.

(b) PEDIATRIC QUALITY MEASURES PROGRAM.—Section 1139A(i) of the Social Security Act (42 U.S.C. 1320b–9a(i)) is amended—

(1) by striking ''Out of any'' and inserting the following:

''(1) IN GENERAL.—Out of any'';

(2) by striking ''there is appropriated for each'' and inserting ''there is appropriated—

''(A) for each'';

(3) by striking '', and there is appropriated for the period'' and inserting '';

''(B) for the period'';

(4) by striking ''. Funds appropriated under this subsection shall remain available until expended.'' and inserting ''; and''; and

(5) by adding at the end the following:

''(C) for the period of fiscal years 2018 through 2022, $75,000,000 for the purpose of carrying out this section (other than subsections (e), (f), and (g)).

''(2) AVAILABILITY.—Funds appropriated under this subsection shall remain available until expended.''.

SEC. 303. EXTENSION OF OUTREACH AND ENROLLMENT PROGRAM.

(a) IN GENERAL.—Section 2113 of the Social Security Act (42 U.S.C. 1397mm) is amended—

(1) in subsection (a)(1), by striking ''2017'' and inserting ''2022''; and

(2) in subsection (g)—

(A) by striking ''and $40,000,000'' and inserting '', $40,000,000''; and

(B) by inserting after ''2017'' the following: '', and $100,000,000 for the period of fiscal years 2018 through 2022''.

(b) MAKING ORGANIZATIONS THAT USE PARENT MENTORS ELIGIBLE TO RECEIVE GRANTS.—Section 2113(f) of the Social Security Act (42 U.S.C. 1397mm(f)) is amended—

(1) in paragraph (1)(E), by striking ''or community-based doula programs'' and inserting '', community-based doula programs, or parent mentors''; and

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

''(5) PARENT MENTOR.—The term 'parent mentor' means an individual who—

''(A) is a parent or guardian of at least one child who is an eligible child under this title or title XIX; and

''(B) is trained to assist families with children who have no health insurance coverage with respect to improving the social determinants of the health of such children, including by providing—

''(i) education about health insurance coverage, including, with respect to obtaining such coverage, eligibility criteria and application and renewal processes;

''(ii) assistance with completing and submitting applications for health insurance coverage;

''(iii) a liaison between families and representatives of State plans under title XIX or State child health plans under this title;

''(iv) guidance on identifying medical and dental homes and community pharmacies for children; and

''(v) assistance and referrals to successfully address social determinants of children's health, including poverty, food insufficiency, and housing.''.

(c) EXCLUSION FROM MODIFIED ADJUSTED GROSS INCOME.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended—

(1) in the first paragraph (14), relating to income determined using modified adjusted gross income, by adding at the end the following new subparagraph:

''(J) EXCLUSION OF PARENT MENTOR COMPENSATION FROM INCOME DETERMINATION.—Any nominal amount received by an individual as compensation, including a stipend, for participation as a parent mentor (as defined in paragraph (5) of section 2113(f)) in an activity or program funded through a grant under such section 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.''; and

(2) by striking ''(14) EXCLUSION'' and inserting ''(15) EXCLUSION''.

SEC. 304. EXTENSION AND REDUCTION OF ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR CHIP.

Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended in the second sentence by inserting ''and during the period that begins on October 1, 2019, and ends on September 30, 2020, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 11.5 percentage points'' after ''23 percentage points,''.

SEC. 305. MODIFYING REDUCTIONS IN MEDICAID DSH ALLOTMENTS.

Section 1923(f)(7)(A) of the Social Security Act (42 U.S.C. 1396r–4(f)(7)(A)) is amended—

(1) in clause (i), in the matter preceding subclause (I), by striking ''2018'' and inserting ''2020''; and

(2) in clause (ii), by striking subclauses (I) through (VIII) and inserting the following:

''(I) $4,000,000,000 for fiscal year 2020; and

''(II) $8,000,000,000 for each of fiscal years 2021 through 2025.''.

SEC. 306. PUERTO RICO AND THE VIRGIN ISLANDS MEDICAID PAYMENTS.

(a) INCREASED CAP.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (A), by inserting ''(or, with respect to fiscal years 2018 and 2019, increased by such percentage increase plus one percentage point)'' after ''beginning of the fiscal year''; and

(B) in subparagraph (B), by inserting ''(or, with respect to fiscal years 2018 and 2019, increased by such percentage increase plus one percentage point)'' after ''percentage increase referred to in subparagraph (A)'';

(2) in paragraph (5)—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B), (C), (D), (E), and (F)''; and

(B) by adding at the end the following new subparagraphs:

''(C) The amount of the increase otherwise provided under subparagraph (A) for Puerto Rico shall be further increased by $880,000,000.

''(D)(i) For the period beginning October 1, 2017, and ending December 31, 2019, the amount of the increase otherwise provided under subparagraph (A) for Puerto Rico shall be further increased by $120,000,000 if the Financial Oversight and Management Board for Puerto Rico established under section 101 of the Puerto Rico Oversight, Management, and Economic Stability Act (48 U.S.C. 2121) certifies by a majority vote that Puerto Rico has taken reasonable and appropriate steps during such period to—

''(I) reduce fraud, waste, and abuse under the program under title XIX;

''(II) implement strategies to reduce unnecessary, inefficient, or excessive spending under title XIX;

''(III) improve the use and availability of Medicaid data for program operation and oversight; and

''(IV) improve the quality of care and patient experience for individuals enrolled under the program under title XIX.

''(ii) As a condition of any additional increase pursuant to clause (i), not later than October 1, 2018, Puerto Rico shall submit to the Financial Oversight and Management Board for Puerto Rico a report regarding steps taken to achieve each of the goals described in subclauses (I) through (IV) of clause (i).

''(E) Payments under section 1903(a)(8) for a quarter of a fiscal year shall not be taken into account in applying subsection (f) (as increased in accordance with this paragraph and paragraphs (1), (2), (3), and (4)) to Puerto Rico or the Virgin Islands for such fiscal year.

''(F)(i) For the period beginning October 1, 2017, and ending December 31, 2019, the amount of the increase otherwise provided under subparagraph (A) for the Virgin Islands shall be further increased by an amount equal to the per capita equivalent of the total amount of the increase provided for Puerto Rico under subparagraphs (C) and (D) for such period.

''(ii) For purposes of clause (i), the term 'per capita equivalent' means the ratio of—

''(I) the population of the Virgin Islands, as determined by the most recent census estimate released by the Bureau of the Census before September 4, 2017; to

''(II) the population of Puerto Rico, as so determined.''.

(b) FEDERAL MATCH FOR MEDICAL PERSONNEL AND FRAUD REDUCTION.—Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) is amended—

(1) in paragraph (2)(A), by inserting ''subject to paragraph (8),'' before ''an amount'';

(2) in paragraph (6)—

(A) in subparagraph (B), by inserting ''subject to paragraph (8),'' before ''75 per centum''; and

(B) by striking at the end ''plus'';

(3) in paragraph (7), by striking at the end the period and inserting ''; plus'' ; and

(4) by adding at the end the following new paragraph:

''(8) for quarters during the period beginning January 1, 2018, and ending December 31, 2019, paragraphs (2)(A) and (6) shall apply with respect to Puerto Rico and the Virgin Islands as if—

''(A) the reference to '75 per centum' in paragraph (2)(A) were a reference to '90 per centum'; and

''(B) the reference to '75 per centum' in paragraph (6)(B) were a reference to '90 per centum'.''.

TITLE II—OFFSETS

SEC. 401. MEDICAID THIRD PARTY LIABILITY PROVISIONS.

(a) MEDICAID THIRD PARTY LIABILITY.—

(1) DELAY OF BIPARTISAN BUDGET ACT OF 2013 THIRD PARTY LIABILITY PROVISIONS.—

(A) IN GENERAL.—Section 202(c) of the Bipartisan Budget Act of 2013 (Public Law 113–67; 127 Stat. 1177; 42 U.S.C. 1396a note), as amended by section 211 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93; 128 Stat. 1047; 42 U.S.C. 1396a note) and section 220 of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10), is amended by striking ''2017'' and inserting ''2019''.

(B) EFFECTIVE DATE; TREATMENT.—The amendment made by subparagraph (A) shall take effect on September 30, 2017, and shall apply with respect to any open claims, including claims generated or filed, after such date.

(2) CLARIFICATION OF DEFINITIONS APPLICABLE TO THIRD PARTY LIABILITY.—

(A) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

''(nn) RESPONSIBLE THIRD PARTY AND HEALTH INSURER DEFINITIONS.—For purposes of subsection (a)(25) and section 1903(d)(2)(B):

''(1) RESPONSIBLE THIRD PARTY.—The term 'responsible third party' means a health insurer, a pharmacy benefit manager to the extent the pharmacy benefit manager provides information under this title for the purpose of coordinating benefits, an accountable care organization under section 1899, or any other party that is, by statute, contract, or agreement, legally responsible for payment of a

claim for a health care item or service. Such term does not include a party if payment by such party has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State, or under an automobile or liability insurance policy or plan (including a self-insured plan), or under no fault insurance.

''(2) HEALTH INSURER.—The term 'health insurer' means a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a self-insured plan, a fully-insured plan, a service benefit plan, a medicaid managed care plan under section 1903(m) or 1932, and any other health plan determined appropriate by the Secretary.''.

(B) CONFORMING AMENDMENTS.—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended—

(i) in subparagraph (A), in the matter preceding clause (i), by striking ''third parties'' and all that follows through ''item or service)'' and inserting ''responsible third parties'';

(ii) in subparagraph (G), by striking ''health insurer'' and all that follows through ''item or service)'' and inserting ''responsible third party'';

(iii) in subparagraph (I), in the matter preceding clause (i), by striking ''health insurers'' and all that follows through ''item or service'' and inserting ''responsible third parties''; and

(iv) by inserting ''responsible'' before ''third'' each place it appears in subparagraphs (A)(i), (A)(ii), (C), (D), and (H).

(3) REMOVAL OF SPECIAL TREATMENT OF CERTAIN TYPES OF CARE AND PAYMENTS UNDER MEDICAID THIRD PARTY LIABILITY RULES.—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)), as amended by section 202(c) of the Bipartisan Budget Act of 2013 (after application of paragraph (1)), is amended—

(A) in subparagraph (E)—

(i) in the matter preceding clause (i), by striking ''prenatal or preventive'' and all that follows through ''State plan'' and inserting ''items and services provided under the program required under the State plan pursuant to paragraph (62)''; and

(ii) in clause (i)—

(I) by striking ''such service'' and inserting ''such items and services''; and

(II) by striking each place it appears ''such services'' and inserting ''such items and services'' each such place; and

(B) by striking subparagraph (F).

(4) CLARIFICATION OF ROLE OF HEALTH INSURERS WITH RESPECT TO THIRD PARTY LIABILITY.—

(A) IN GENERAL.—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)), as amended by paragraph (3), is further amended by inserting after subparagraph (E) the following new subparagraph:

''(F) that—

''(i) in the case of a State that provides medical assistance under this title through a contract with a health insurer, such contract shall specify any responsibility of such health insurer (or other entity) with respect to recovery of payment from responsible third parties pursuant to the delegation or transfer by the State to such insurer (or other entity) of a right described in subparagraph (I)(ii); and

''(ii) in the case of a State that under a contract described in clause (i) delegates or transfers to a health insurer (or other entity) a right described in such clause, the State shall provide assurances to the Secretary that the State laws referred to in subparagraph (I), with respect to each responsibility of such health insurer (or other entity) specified under such clause, confer to such health insurer (or other entity) the authority of the State with respect to the requirements specified in clauses (i) through (iv) of such subparagraph (I);''.

(B) TREATMENT OF COLLECTED AMOUNTS.—Section 1903(d)(2)(B) of the Social Security Act (42 U.S.C. 1396b(d)(2)(B)) is amended by adding at the end the following: ''For purposes of this subparagraph, reimbursements made by a responsible third party to health insurers (as defined in section 1902(nn)) pursuant to section 1902(a)(25)(F)(ii) shall be treated in the same manner as reimbursements made to a State under the previous sentence.''.

(5) INCREASING STATE FLEXIBILITY WITH RESPECT TO THIRD PARTY LIABILITY.—Section 1902(a)(25)(I) of the Social Security Act (42 U.S.C. 1396a(a)(25)(I)) is amended—

(A) in clause (i), by striking ''medical assistance under the State plan'' and inserting ''medical assistance under a State plan (or under a waiver of the plan)'';

(B) by striking clause (ii) and inserting the following new clause:

''(ii) accept—

''(I) any State's right of recovery and the assignment to any 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 respective State's plan (or under a waiver of the plan); and

''(II) as a valid authorization of the responsible third party for the furnishing of an item or service to an individual eligible to receive medical assistance under this title, an authorization made on behalf of such individual under the State plan (or under a waiver of such plan) for the furnishing of such item or service to such individual;'';

(C) in clause (iii)—

(i) by striking ''respond to'' and inserting ''not later than 60 days after receiving''; and

(ii) by striking ''; and'' at the end and inserting '', respond to such inquiry; and''; and

(D) in clause (iv), by inserting ''a failure to obtain a prior authorization,'' after ''claim form,''.

(6) STATE INCENTIVE TO PURSUE THIRD PARTY LIABILITY FOR NEWLY ELIGIBLES.—Section 1903(d)(2)(B) of the Social Security Act (42 U.S.C. 1396b(d)(2)(B)), as amended by paragraph (4)(B), is further amended by adding at the end the following: ''In the case of expenditures for medical assistance provided during 2017 and subsequent years for individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), in determining the amount, if any, of overpayment under this subparagraph with respect to such medical assistance, the Secretary shall apply the Federal medical assistance percentage for the State under section 1905(b), notwithstanding the application of section 1905(y).''.

(b) COMPLIANCE WITH THIRD PARTY INSURANCE REPORTING.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

''(ee) Notwithstanding subsection (b), for any year beginning after 2019, if a State fails to comply with the requirements of section 1902(a)(25) with respect to each calendar quarter in such year, the Secretary may reduce the Federal medical assistance percentage by 0.1 percentage point for calendar quarters in each subsequent year in which the State fails to so comply.''.

(c) APPLICATION TO CHIP.—

(1) IN GENERAL.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (B) through (R) as subparagraphs (C) through (S), respectively; and

(B) by inserting after subparagraph (A) the following new subparagraph:

''(B) Section 1902(a)(25) (relating to third party liability).''.

(2) MANDATORY REPORTING.—Section 1902(a)(25)(I)(i) of the Social Security Act (42 U.S.C. 1396a(a)(25)(I)(i)), as amended by subsection (a)(5), is further amended—

(A) by striking ''(and, at State option, child'' and inserting ''and child''; and

(B) by striking ''title XXI)'' and inserting ''title XXI''.

(d) TRAINING ON THIRD PARTY LIABILITY.—Section 1936 of the Social Security Act (42 U.S.C. 1396u–6) is amended—

(1) in subsection (b)(4), by striking ''and quality of care'' and inserting '', quality of care, and the liability of responsible third parties (as defined in section 1902(nn))''; and

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

''(f) THIRD PARTY LIABILITY TRAINING.—With respect to education or training activities carried out pursuant to subsection (b)(4) with respect to the liability of responsible third parties (as defined in section 1902(nn) for payment for items and services furnished under State plans (or under waivers of such plans)) under this title, the Secretary shall—

''(1) publish (and update on an annual basis) on the public Internet website of the Centers for Medicare & Medicaid Services a dedicated Internet page containing best practices to be used in assessing such liability;

''(2) monitor efforts to assess such liability and analyze the challenges posed by that assessment;

''(3) distribute to State agencies administering the State plan under this title information related to such efforts and challenges; and

''(4) provide guidance to such State agencies with respect to State oversight of efforts under a medicaid managed care plan under section 1903(m) or 1932 to assess such liability.''.

(e) DEVELOPMENT OF MODEL UNIFORM FIELDS FOR STATES TO REPORT THIRD PARTY INFORMATION.—Not later than January 1, 2019, the Secretary of Health and Human Services shall, in consultation with the States, develop and make available to the States a model uniform reporting set of reporting fields and accompanying guidance documentation that States shall use for purposes of—

(1) reporting information to the Secretary within the Transformed Medicaid Statistical Information System (T–MSIS) (or a successor system); and

(2) collecting information that identifies responsible third parties (as defined in subsection (nn) of section 1902 of the Social Security Act (42 U.S.C. 1396a), as added by subsection (a)(2)(A)) and other relevant information for ascertaining the legal responsibility of such third parties to pay for care and services available under the State plan (or under a waiver of the plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) or under the State child health plan under title XXI of such Act (42 U.S.C. 1397 et seq.).

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), this section and the amendments made by this section (other than as specified in the preceding provisions of this section) shall take effect on October 1, 2019, and shall apply to medical assistance or child health assistance provided on or after such date.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or a State child health plan for child health assistance under title XXI of such Act (42 U.S.C. 1397aa et seq.), that the Secretary of

Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made under this section, such plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this 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 such session shall be deemed to be a separate regular session of the State legislature.

SEC. 402. TREATMENT OF LOTTERY WINNINGS AND OTHER LUMP-SUM INCOME FOR PURPOSES OF INCOME ELIGIBILITY UNDER MEDICAID.

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

(1) in subsection (a)(17), by striking ''(e)(14), (e)(14)'' and inserting ''(e)(14), (e)(15)''; and

(2) in subsection (e)(14), as amended by section 303(c), by adding at the end the following new subparagraph:

''(K) 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, 2018) 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, shall continue to be eligible for medical assistance to the extent that the State determines, under procedures established by the State (in accordance with standards 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)—

''(I) before the date on which the individual loses such eligibility, inform the individual—

''(aa) of the individual's opportunity to enroll in a qualified health plan offered through an Exchange established under title I of the Patient Protection and Affordable Care Act during the special enrollment period specified in section 9801(f)(3) of the Internal Revenue Code of 1986 (relating to loss of Medicaid or CHIP coverage); and

''(bb) of the date on which the individual would no longer be considered ineligible by reason of clause (i) to receive medical assistance under the State plan or under any waiver of such plan and be eligible to reapply to receive such medical assistance; and

''(II) provide technical assistance to the individual seeking to enroll in such a qualified health plan.

''(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 gambling activities described in section 1955(b)(4) of title 18, United States Code).

''(II) Damages received, whether by suit or agreement and whether as lump sums or as periodic payments (other than monthly payments), on account of causes of action other than causes of action arising from personal physical injuries or physical sickness.

''(III) Income received as liquid assets from the estate (as defined in section 1917(b)(4)) of a deceased individual.''.

(b) RULES OF CONSTRUCTION.—

(1) INTERCEPTION OF LOTTERY WINNINGS ALLOWED.—Nothing in the amendment made by subsection (a)(2) 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 (42 U.S.C. 1396 et seq.) for medical assistance furnished to the individual.

(2) APPLICABILITY LIMITED TO ELIGIBILITY OF RECIPIENT OF LOTTERY WINNINGS OR LUMP SUM INCOME.—Nothing in the amendment made by subsection (a)(2) 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 who received qualified lottery winnings or qualified lump-sum income (as defined in subparagraph (K) of such section 1902(e)(14), as added by subsection (a)(2) of this section).

SEC. 403. ADJUSTMENTS TO MEDICARE PART B AND PART D PREMIUM SUBSIDIES FOR HIGHER INCOME INDIVIDUALS.

(a) IN GENERAL.—Section 1839(i)(3)(C)(i)(II) of the Social Security Act (42 U.S.C. 1395r(i)(3)(C)(i)(II)) is amended, in the table, by striking the last row and inserting the following new rows:

''More than $160,000 but less than $500,000	80 percent
At least $500,000	100 percent.''.

(b) JOINT RETURNS.—Section 1839(i)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1395r(i)(3)(C)(ii)) is amended by inserting before the period the following: ''except, with respect to the dollar amounts applied in the last row of the table under subclause (II) of such clause (and the second dollar amount specified in the second to last row of such table), clause (i) shall be applied by substituting dollar amounts which are 175 percent of such dollar amounts for the calendar year''.

(c) INFLATION ADJUSTMENT.—Section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is amended—

(1) in paragraph (5)—

(A) in subparagraph (A), by striking ''In the case'' and inserting ''Subject to subparagraph (C), in the case'';

(B) in subparagraph (B), by striking ''subparagraph (A)'' and inserting ''subparagraph (A) or (C)''; and

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

''(C) TREATMENT OF ADJUSTMENTS FOR CERTAIN HIGHER INCOME INDIVIDUALS.—

''(i) IN GENERAL.—Subparagraph (A) shall not apply with respect to each dollar amount in paragraph (3) of $500,000.

''(ii) ADJUSTMENT BEGINNING 2027.—In the case of any calendar year beginning after 2026, each dollar amount in paragraph (3) of $500,000 shall be increased by an amount equal to—

''(I) such dollar amount, multiplied by

''(II) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with August of the preceding calendar year exceeds such average for the 12-month period ending with August 2025.''; and

(2) in paragraph (6)(B), by inserting ''(other than $500,000)'' after ''the dollar amounts''.

The SPEAKER pro tempore. The bill shall be debatable for 1 hour equally divided and controlled by the chair and ranking minority member of the Committee on Energy and Commerce.

The gentleman from Oregon (Mr. WALDEN) and the gentleman from New Jersey (Mr. PALLONE) each will control 30 minutes.

The Chair recognizes the gentleman from Oregon.

Mr. WALDEN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, we are here today to consider a very, very important public health bill, H.R. 3922, the CHAMPIONING HEALTHY KIDS Act. This legislation funds a 5-year extension of the Children's Health Insurance Program, known as CHIP, along with a 2-year extension of community health centers and numerous other critically important public health programs.

This bill will deliver quality healthcare and peace of mind to millions of Americans. The patients and families helped by this legislation are our neighbors and our friends. More than 8 million children receive CHIP-funded coverage, and more than 25 million patients are served by our community health centers and other important programs.

This 5-year funding of CHIP marks one of the longest extensions of the program since it was created 20 years ago. The policy we are considering mirrors the bipartisan policy that has been introduced and voted out of our sister

committee in the United States Senate.

Funding for these important programs expired September 30. The committee worked on a bipartisan basis well before this deadline to try and reach a bipartisan agreement on a range of policies to offset the costs of this very critically important funding extension.

Three times, at the request of the Democrats, we delayed committee action—three times. We tried to find offsets that were agreeable as we have always been able to do before. Unfortunately, that was not the case this time. These delays meant Congress went past the deadline of September 30.

While States still have rollover CHIP funds available and the next wave of community health center funds won't go out until next year, we cannot wait any longer. Patients cannot wait any longer. Patients need care, these critical programs need funding, and we must move forward.

In my district alone, there are 12 federally qualified health center organizations, with 63 delivery sites. They leverage $41 million in Federal money in order to serve more than 240,000 patients in Oregon's Second District. These health centers—and I have visited many of them—are prevention and public health in action, often serving as the main provider of care for people for hundreds of miles around.

We are also extending the National Health Service Corps and the Teaching Health Center Graduate Medical Education program. Now, Mr. Speaker, these are really important workforce programs that place qualified providers into some of the most underserved areas of our country.

In addition to community health centers and the workforce programs, this bill extends the funding for the Special Diabetes Program and the Family-to-Family Health Information centers, the Personal Responsibility Program, and the Youth Empowerment Program. These locally based, patient-centered organizations provide comprehensive services to those most in need.

Moreover, this legislation eliminates 2 years of the across-the-board cuts to Medicaid allotments called for under the Affordable Care Act, ObamaCare. We delay those cuts for disproportionate share hospitals for 2 years. Medicaid DSH funding represents an important component of many State Medicaid programs and is particularly relied upon by many States to help provide additional resources to key safety net providers.

Now, while this relief is only temporary and does not address the larger structural challenges under ObamaCare, it would give Congress time to explore what budget-neutral approaches there might be to allocate existing DSH dollars on a more equitable and fair basis. In my State alone of Oregon, hospitals have told me this relief in this bill, just for them, represents $6.8 million over the next 2 years that they can use to help low-income people get access to hospital care.

Now, in paying for this package—and this is the area where we have the most disagreement with the Democrats—we have taken a fiscally responsible approach, like using existing funding streams for prevention and public health efforts, ensuring high-dollar lottery winners are removed from the Medicaid program so its limited resources can be prioritized for the most vulnerable, and stopping individuals on the Affordable Care Act's exchanges from gaming the system.

The bill also asks Medicare's wealthiest 1 percent, people who are retired and making $40,000 a month—not a year, a month—to pay about $135 more for their Medicare just on parts B and D that is already subsidized by 75 percent, just a little more so we can fund children's health insurance for 5 years.

While it was not ultimately possible, unfortunately, to reach consensus on some of the policies to offset the new funding in this bill, there is broad bipartisan agreement on the core policies contained in this legislation, and I believe there is bipartisan support for many of the reasonable and fiscally responsible offsets contained in H.R. 3922.

Mr. Speaker, this is good legislation. This is long-overdue legislation. It reflects the good work done by your House Energy and Commerce Committee, and I urge my colleagues to put politics aside today and ensure these vital programs get the funding extensions they need. We are over the deadline. It is time to act.

Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today to speak in opposition to H.R. 3922, a partisan bill to reauthorize the Children's Health Insurance Program, or CHIP, as well as community health centers and other public health programs.

It pains me to be here today, because this should not be a partisan bill. I have tried for months to negotiate with Republicans to develop a bipartisan compromise, but House Republicans chose to spend the first 9 months of this year trying to repeal the Affordable Care Act. They failed, but now House Republicans are using the reauthorization of CHIP and community health centers as a way to once again sabotage the ACA.

Make no mistake, Mr. Speaker: if Republicans can't repeal the ACA outright, they will cripple it any time they can.

This time, Republicans are risking the healthcare of nearly 9 million children and the care of families all around the country that use community health centers. They are risking that care because this partisan bill has no chance of ever becoming law.

By taking this route, Republicans are guaranteeing that CHIP and community health centers will not be reauthorized until the end of the year, and that is extremely unfortunate.

Mr. Speaker, I strongly support CHIP, our community health centers, and all of our public health programs that are extended in this bill. These programs have traditionally been bipartisan, but the bill before us extends these programs by taking billions of dollars away from the Affordable Care Act and undermining Medicare.

In short, this Republican bill offers a false choice. On one hand, it strips healthcare away from upwards of 680,000 Americans and guts the Prevention Fund, which pays for immunization and vaccines, lead poisoning prevention, opioid treatment, and many other important programs; on other hand, it reauthorizes these important programs. Democrats strongly support reauthorization of these programs, but we reject the way Republicans are paying for them.

Mr. Speaker, there are so many other policies that save money, countless alternatives that Democrats have offered to Republicans for months. Yesterday I offered an alternative that would have provided a robust reauthorization and extension of these important programs, and it was paid for in a commonsense way.

My alternative would have changed the timing of payments to Medicare Advantage Plans. This approach was recommended by both the GAO and the Office of the Inspector General, but Republicans rejected it in the Rules Committee. They wouldn't even allow it to come before the full House for a vote. And why is because they would rather use reauthorization of CHIP and community health centers as another way to sabotage the Affordable Care Act.

I simply reject that approach and strongly urge a ''no'' vote.

Mr. Speaker, I reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, before I call on my next person to say something here, there are 17,000 children in Mr. PALLONE's district and 14 health centers that, if he votes ''no,'' he will be voting against.

By the way, the offset he recommended, people who are watching this need to know, would violate statute and it would be a PAYGO violation. That is why it was not acceptable.

See, this is the problem we faced. We delayed three times at their request only to be offered up a pay-for that violates statute and violates our PAYGO rules. We could not accept that. We have to operate within the law like everyone else in America.

Mr. Speaker, I yield 4 minutes to the gentleman from Texas (Mr. BURGESS).

Mr. BURGESS. Mr. Speaker, I thank the gentleman for yielding the time, for the recognition.

Let me just say, I want to thank members of the Health Subcommittee, both sides of the dais, who have worked hard on this legislation, and it is unfortunate that it was not brought to the floor of the House in the month of September.

From a subcommittee perspective, we were ready. We had our legislative hearings in June. We were delayed one time when the whole House recessed after the shooting of the Members at the baseball practice, but we rescheduled for 2 weeks later, and we had a successful hearing. We had a good hearing; a lot of facts were laid out. We came up with commonsense legislation that was offset in a responsible way. The offsets are not draconian.

We have before us a bill today that will, in fact, fund some of the Nation's most important public health programs. It does fund the State Children's Health Insurance for 5 years, one of the longest extensions for this program since its inception in 1996. It will ensure that children and families who rely on this program will continue to receive the access they need. It also includes, in a fiscally responsible way, to delay the harmful ObamaCare-mandated cuts to safety net hospitals, who also provide care to underserved patients.

Now, think about that for a minute. We are accused of undermining ObamaCare, but here is a cut that ObamaCare mandates to your safety net hospitals across the country—not just in Texas, but across the country—and we are replacing that today in a fiscally responsible way.

It provides funding for community health centers, an important key part of healthcare in communities across the country. It will help the Americans who rely on these vital health services.

Not only does the bill provide assistance for underserved populations, but it does so without adding to the national debt. The Committee for a Responsible Federal Budget called this a responsible health package, noting that the $18 billion cost is fully offset, with savings beyond the 10-year budget window.

Other groups have also been supportive: Texas Hospital Association, Texas Health Resources—for me back home—Children's Hospital, and a number of healthcare organizations.

We have data from MACPAC, whose job it is to advise Congress on Medicaid and CHIP policy; and MACPAC has advised us that, under current law, there are no new Federal funds for State Children's Health Insurance for fiscal year 2018 and beyond. Unless Congress acts to renew funding, all States will experience a shortfall in CHIP funds for 2018, which means, if someone is contemplating a ''no'' vote on this bill, if you are contemplating a ''no'' vote, you do need to be aware that if you live in the States of Arizona and Minnesota, you ran out of money in October of 2017; North Carolina, same situation. Oregon runs out next month. Vermont runs out next month. You need to think about your ''no'' vote before you apply it.

Every single U.S. territory, with the exception of Puerto Rico, ran out of money in the month of October.

So those are a few facts that people do need to bear in mind, if they vote ''no'' on this bill, what the actual implications of that are.

Yesterday, during debate on the rule, I heard a lot of discussion about taking money out of the Prevention Fund. It doesn't take money out of the Prevention Fund, but it does provide discretion for some prevention and public health dollars. It takes it away from the executive branch and redirects these dollars to proven public health programs that enjoy broad bipartisan support in Congress, like community health centers.

So we are fulfilling our Article I responsibility. We shouldn't just be giving everything to the administration to decide how to spend money, whether it be a Democratic or Republican administration. This is the right thing to do.

I am proud of the work done by our subcommittee. I think our subcommittee staff has performed admirably on both sides of the dais.

Mr. Speaker, I urge a ''yes'' vote on the bill. It is time to act, as our chairman has said.

□ 0930

Mr. PALLONE. Mr. Speaker, I yield 1½ minutes to the gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. Mr. Speaker, I thank our distinguished ranking member.

Mr. Speaker, I rise today to oppose this bill, the so-called CHAMPIONING HEALTHY KIDS Act. First of all, we are a month late and many dollars short. It was the majority that brought it up late. We didn't have anything to do with being late.

Secondly, we are playing political games with the lives of 14 percent of the children in my congressional district who receive their health insurance through the Children's Health Insurance Program and the five federally qualified health centers in my congressional district. They provide medical, dental, and mental health services to almost 55,000 of my constituents every year.

Reauthorizing these historically bipartisan programs is critical to the health and safety of not only my constituents but millions of others across our country.

Today, the Republican majority is holding them hostage by insisting to fund these programs by means-testing Medicare beneficiaries, kicking individuals who purchase their health coverage on the marketplaces off their insurance, and gutting the Public Health Prevention Fund established in the Affordable Care Act.

Remember, the Republicans have set their budget based on eliminating the Affordable Care Act. My State of California will run out of funding for CHIP sometime between now and December. This has never happened before in the history of this program.

The SPEAKER pro tempore. The time of the gentlewoman has expired.

Mr. PALLONE. Mr. Speaker, I yield an additional 30 seconds to the gentlewoman from California.

Ms. ESHOO. Mr. Speaker, the community health centers in my district have told me about the difficult decisions they have to make because Congress has not reauthorized their funding, including layoffs of physicians and closing clinics' doors. We are playing with people's lives here.

If we can't find the funding for these important bipartisan programs, then we don't deserve to be Members of Congress. I cannot support a bill that hurts people instead of helping them.

Mr. WALDEN. Mr. Speaker, I yield myself such time as I may consume to respond.

Mr. Speaker, my friend, and she is my friend from California, obviously was not aware of the fact that it was her party, her leader, who asked us on three occasions to delay bringing this to the floor, including you could look at the CQ article from October 23 where Mr. PALLONE says he hopes it doesn't come to the floor.

This was a bipartisan agreement not to bring it until we could try to work these things out. We were all trying to figure out how to get this done.

When it comes to Medicare, remember, we are talking about people making $40,000 a month paying $135 a month more. We can fully fund children's health insurance for millions of children.

Mr. Speaker, I yield 1½ minutes to the gentlewoman from Washington (Mrs. MCMORRIS RODGERS), the conference chairwoman.

Mrs. MCMORRIS RODGERS. Mr. Speaker, I thank the chairman for his tremendous leadership on the reauthorization of CHIP, including many vital public health programs.

CHIP provides healthcare coverage for some 9 million children—more than a million in Washington State. We all need to remember how important this program is for the health of some of the most vulnerable.

Some States, like mine, are expecting to run out of CHIP funding soon. It is crucial that we move forward now.

This bill also reauthorizes the Teaching Health Center Graduate Medical Education program, providing funding for 2 years, with a robust increase. This not only preserves current programs like the Spokane Teaching Health Center, but it also provides funding for the creation of new programs in communities that need them.

Mr. Speaker, this bill makes a real difference to those who need healthcare, and I encourage my colleagues to support it.

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, it is the ultimate absurdity for my colleague, the chairman of the Energy and Commerce Committee, to suggest that somehow I control when a bill comes to the floor of the House of Representatives.

The only reason that the Republicans ever delayed bringing this vote to the floor is because they know and I know that, if this bill is partisan, it will

never become law. It will go to the Senate, and it will sit there, and the only way that it is going to become law is if it is a bipartisan effort that actually accomplishes something and gets most people to support it.

We could keep listening to the other side all day say: Oh, the Democrats delayed the vote. The Democrats delayed the vote.

The vote shouldn't be held today. The vote should be delayed today because this is going nowhere. This bill is going nowhere. They know it. You want to keep saying it? You can say it all day for the next hour, but it is the ultimate of absurdity.

Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GENE GREEN), who is the ranking member of our Health Subcommittee.

Mr. GENE GREEN of Texas. Mr. Speaker, I thank my ranking member for yielding time to me.

I rise to oppose H.R. 3922. I got elected to Congress to expand access for healthcare. I am not a doctor, I am not a nurse, but as Members of Congress, we can do as much damage as someone who isn't a doctor or nurse by legislation that we see today.

And while I strongly support extending funding for the Children's Healthcare Insurance Program and federally qualified health centers, delaying cuts to disproportionate share hospital payments, advancing our other bipartisan healthcare programs, this legislation includes offsets that undermine access to cover these services.

Again, my goal in Congress was to expand healthcare, and this bill restricts that access. Two-thirds of Medicaid dollars go to children. If you cut Medicaid, you are cutting those children's benefits. This bill cuts children from Medicaid, and it gives money to the children who are less poor on CHIP. We need both programs. We don't need one or the other.

Both CHIP and FQHCs are bedrocks of our healthcare system, providing health insurance to almost 9 million lower-income children serving on the front lines by providing high-quality primary and preventative care to more than 25 million Americans.

Congress let funding for these programs expire last month, the first time in our history, since the 1960s, that the FQHCs and the CHIP program were not bipartisan. That is the step this House is making today by doing this.

It should be bipartisan because it has always been bipartisan. Unfortunately, instead of bipartisan negotiations looking for a compromise, the process was derailed. The bill cuts, again, Medicaid. Two-thirds are children, to help poor children, and limit their access.

The Prevention Fund funds the Centers for Disease Control. We have any number of future illnesses that we need the CDC to have the ability to fight that, and here we are, cutting vaccinations in our communities. We are cutting infectious disease detection and prevention.

Mr. Speaker, I urge my colleagues to vote ''no,'' and let's expand access and not restrict it.

Mr. WALDEN. Mr. Speaker, I would point out there are about 50,000 kids that Mr. GREEN may be voting against today in the Houston area if this goes down and we can't get this over to the Senate and work it out with them. Twice he has voted to cut the Prevention Fund and use it for other purposes.

Mr. Speaker, I yield 1½ minutes to the gentleman from New Jersey (Mr. LANCE).

Mr. LANCE. Mr. Speaker, I rise in support of this legislation. This package is the product of our work on the Energy and Commerce Committee under the leadership of Chairman WALDEN. This legislation accomplishes the very important goals of reauthorizing the Children's Health Insurance Program, renewing funding for community health centers, and extending critical resources for Medicaid in Puerto Rico.

One of the first votes I cast in Congress was for CHIP, creating a fiscally responsible health program that now serves 8.5 million children in the United States.

I continue to support community health centers and the work they do in areas like Dover and Somerville, New Jersey, in the district I serve.

We also cannot forget about the many families and children in Puerto Rico, who also benefit from the Medicaid program. That is why I have teamed up with Resident Commissioner GONZÁLEZ-COLÓN, to make sure low-cost Federal healthcare continues to be made available to our American children in Puerto Rico.

Mr. Speaker, I urge passage of this legislation and for the United States Senate to act as soon as possible.

Mr. PALLONE. Mr. Speaker, I yield 1½ to the gentleman from New York (Mr. ENGEL).

Mr. ENGEL. Mr. Speaker, I am deeply saddened by the situation we are in today. Historically, CHIP and community health centers have been bipartisan priorities. We are talking about programs that provide healthcare for millions of American children and serve some of our country's most vulnerable citizens.

Yet my Republican colleagues have inexplicably taken these programs hostage, tucking into this bill new attempts to undermine Medicare, sabotage the ACA, and strip hardworking Americans of their health insurance, not to mention they are trying to extort these harmful policy changes a month after they let CHIP and community health center funding expire. This is absolutely unconscionable because, make no mistake, these cuts will hurt the same Americans who depend on CHIP and community health centers.

My Democratic colleagues and I care deeply about these programs. That is why we have sounded the alarm for months, not just yesterday, for months, and urged the majority to stop wasting time on ACA repeal and get to work on renewing these lifelines for American families.

Mr. Speaker, I am disappointed that didn't happen, and I am disappointed by what is happening now. I urge my colleagues to vote ''no.''

Mr. WALDEN. Mr. Speaker, I yield 1½ minutes to the gentleman from Texas (Mr. OLSON), a very important member of our committee.

Mr. OLSON. Mr. Speaker, I thank the chairman for yielding time to me.

Mr. Speaker, I rise today to strongly encourage my colleagues to support the HEALTHY KIDS Act. There are many reasons to support this bill, but, most importantly, it extends the Children's Health Insurance Program, CHIP, until 2022.

CHIP ensures that children with incomes too low for Medicaid get basic health insurance. Close to 400,000 children in Texas rely on CHIP for access to quality healthcare services. We must act now.

Earlier this year, Hurricane Harvey left a path of destruction across Texas. It put a major strain on our communities and resources that has resulted in moments of uncertainty.

The bottom line is, we must act now. This bill responsibly provides children in need with the proper resources to live a healthy life without adding to our country's deficit.

Mr. Speaker, again, I strongly urge my colleagues to act now. Vote for this bill.

Mr. PALLONE. Mr. Speaker, I yield 1½ minutes to the gentlewoman from Colorado (Ms. DEGETTE), the ranking member of our Oversight Subcommittee.

Ms. DEGETTE. Mr. Speaker, as one of the authors of the original bill 20 years ago, I rise to express deep disappointment that the House has not been able to reach a bipartisan agreement on how to fund the extension of CHIP.

The September 30 deadline has long passed, and now 9 million children and families are waiting anxiously for us to figure this out. My home State of Colorado is likely to run out of CHIP funding in January, with termination notices going out to worried families in the next few weeks.

Yet here we are with a partisan bill that asks us to pay for low-income children's insurance on the backs of seniors and the most vulnerable.

The bill also cuts the Affordable Care Act, which could result in 668,000 people enrolled in ACA plans losing their health insurance. Nobody should have to lose coverage in order for others to keep it. This is a false choice, and it is out of step with what the American people have been calling on us to do. Only the 115th Congress could find a way to make the CHIP bill partisan.

Irrespective of what happens today in this vote, I urge my colleagues to get together across the aisle, across the Capitol, find a way to reauthorize this important bill in a way that doesn't cut benefits for other people. Let's

truly give kids these benefits that they need, and let's move on with our business.

Mr. WALDEN. Mr. Speaker, I yield 1½ minutes to the gentleman from Florida (Mr. BILIRAKIS), an incredible advocate for children and healthcare in America.

Mr. BILIRAKIS. Mr. Speaker, I am so proud to serve on this great committee under the chairman's leadership.

Mr. Speaker, I rise in support of this important bill, which incorporates my bill, the Community CARE Act, which reauthorizes funding for community health centers for the next 2 years.

Community health centers have a proven track record of providing high-quality, cost-efficient healthcare to approximately 25 million Americans, including 7 million children, and 300,000 veterans each year. There are over 100 million coordinated and integrated patient visits through the 1,400 community health centers across the country.

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This bill will reauthorize CHIP for the next 5 years. This program is vital for the roughly 360,000 children on CHIP in Florida alone.

Additionally, this bill provides clarity for CHIP buy-in programs, such as the one we have in Florida. This sets the rules of the road and will ensure that 12,000 children in Florida's CHIP buy-in program will continue to have access to CHIP.

Mr. Speaker, let's get this done now for our children. I urge passage of this important piece of legislation.

Mr. PALLONE. Mr. Speaker, I yield 1½ minutes to the gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, the truth is that Republicans are holding the Children's Health Insurance Program, 9 million kids, and the Community Health Center program, 15 million people, hostage to wreak even more havoc on our healthcare system and make children and seniors sicker and undercut Medicare.

Paying for children's health insurance on the backs of seniors is simply a disgrace. This bill would increase Medicare part D and part B income-related premiums, charging higher income seniors the entire cost. This is a structural attack on Medicare, and that is why the AARP, which supports the Children's Health Insurance Program, opposes this bill. Imposing a 100 percent premium is unfair because these seniors already pay more, and it will drive many out of Medicare altogether, undermining its solvency.

To make matters worse, the Republican income threshold is not based on current income, but on a 2-year period. So, for example, seniors' income is volatile, and if you sold your home, you could get a massive premium penalty, even if you used the money you got from selling your home to buy in to assisted living and that money wasn't available.

Income-related premiums are simply unnecessary. There are many other ways to pay for the CHIP program without using Medicare as an ATM. Democrats have offered reasonable alternatives, but Republicans opposed all of them.

I urge my colleagues to oppose this legislation.

Mr. WALDEN. Mr. Speaker, I yield myself such time as I may consume.

Before I call on my next colleague, I just want to point out that, in Ms. SCHAKOWSKY's district, all we are talking about here is seniors making $41,000 a month—a month—would pay an extra 135 bucks so we can fully fund children's health insurance, community health centers. All these programs in here are funded. We use the Prevention Fund, which is not allocated out in the out-years. It is just a pot of money you can use for prevention and wellness. We actually use that to fund this as well.

This is why we have been unable to reach agreement with the Democrats. It is sad they have made this partisan.

I yield 1 minute to the gentleman from California (Mr. COSTA).

Mr. COSTA. Mr. Speaker, I rise today to speak on behalf of the people of the San Joaquin Valley in favor of H.R. 3922.

The people of the valley whom I represent in California did not send me here to put the lives of children at risk. I have made a commitment to improve access to healthcare for families that I have the honor to represent here in the House. I will continue to meet that commitment. The question is: Will Congress do the same and extend the Children's Health Insurance Program?

My congressional district has perhaps the largest percentage of children who qualify for the Children's Health Insurance Program in the entire country. The coverage is vital to families throughout my district, but it is particularly important to communities like Gustine, Planada, Chowchilla, and Biola, where these healthcare clinics provide such important, valuable healthcare to these children and their families.

Approximately 71 percent of the children in my district receive their medical coverage through the combination of the Children's Health Insurance Program and Medicaid. We cannot let this end.

This bill is not perfect, to be sure, but these children cannot be put at risk with further delays in funding for the important programs that this bill extends. I urge my colleagues to support this legislation.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Florida (Ms. CASTOR), the vice ranking member of our committee.

Ms. CASTOR of Florida. Mr. Speaker, for decades now in America we have worked together to make sure that kids can see a doctor and get the care that they need. Working with pediatricians, families, and advocates back home, we have reached a historic point where almost all kids across the country have health insurance coverage.

The Children's Health Insurance Program, or CHIP, or known in Florida as Florida KidCare, or Healthy Kids, has been an important piece of this historic coverage level. CHIP simply is vital for families, millions of hardworking families, so that their kids can get the checkups, the immunizations, sometimes the critical care that they need so they can be healthy and well.

Now, I chair the bipartisan Children's Healthcare Caucus. We educate and advocate so that kids across America are healthy and well. So it is especially disappointing this year that my Republican colleagues failed to act before CHIP expired.

See, they were consumed all year long with ripping health coverage away, decimating the Affordable Care Act, and radically changing health services provided under Medicaid. In doing so, they let our kids down; they let our families down. And then, at the 11th hour, after the program expired, they come up with a very partisan bill rather than the bipartisan bill that has been the historic backbone of Children's Health Insurance.

Don't take it from me. A lot of the advocates across the country, like pediatricians, obstetricians, gynecologists, March of Dimes, say: Please don't fund CHIP based upon harmful cuts; don't have cuts negatively impact the health of women, children, and families. Pediatricians say: Don't jeopardize other important child health policies in the process.

Let's go back to the drawing board as soon as possible, over the weekend, next week; bring it back to the floor next week, so that families and kids get the care that they need.

This bill today, unfortunately, is simply a delay.

Mr. WALDEN. Mr. Speaker, there they go again: delay, delay, delay; and vote against kids, vote against their hospitals, and vote against their doctors. That is why we couldn't get agreement.

I yield 1½ minutes to the gentleman from Indiana (Mr. BUCSHON).

Mr. BUCSHON. Mr. Speaker, I rise today in strong support of the CHAMPIONING HEALTHY KIDS Act, which extends the State Children's Health Insurance Program, SCHIP, for another 5 years.

In 1997, Congress created S–CHIP in partnership with the States to meet the healthcare needs of lower income kids. Last year, nearly 100,000 Hoosier kids received health insurance thanks to this critical program. I am proud that this legislation will continue to protect vulnerable children in the Eighth District of Indiana.

This bill also extends 2 years of funding for federally qualified health centers, family-to-family health information centers, and other important public health programs. This funding provides important healthcare services, resources, and information for families in the Eighth District and across America.

I urge my colleagues to support passage of the CHAMPIONING HEALTHY KIDS Act.

Mr. PALLONE. Mr. Speaker, I yield 1½ minutes to the gentleman from Vermont (Mr. WELCH).

Mr. WELCH. Mr. Speaker, speaking to my chairman, Chairman WALDEN, I accept your commitment and your leadership on insuring children, but I am speaking to you because I reject the argument that, in order to fund a health insurance program that all of us support, we have to compromise health programs that benefit many other people, including in Vermont. Let me just give an example.

The prevention program in Vermont is really helping people stay well. We had $922,000 that was spent on immunization programs for our kids. We had $377,000 for lead poisoning prevention. Lead poisoning is brutal. We had $372,000 for heart disease prevention and control, and we had over $209,000 for diabetes and prevention control.

So I acknowledge your commitment. I acknowledge the urgency with which your side and our side supports CHIP. But why is it that, if we support it, we don't pay for it? And instead of paying for it directly, coming up with ways to eliminate waste in the healthcare system, we take away our ability to immunize, to prevent lead poisoning, to reduce heart disease? That is my question. The answer for me would be that we go where the waste is.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. PALLONE. I yield the gentleman from Vermont an additional 30 seconds.

Mr. WELCH. The answer to me would be that our committee engages in addressing the waste in healthcare, including high prescription drug costs, rather than take it out of good programs.

Mr. WALDEN. Mr. Speaker, I yield myself such time as I may consume.

I appreciate the gentleman's sincerity. We work well together on lots of issues. He has also voted to use this Prevention Fund for other purposes in the past, as have I.

We don't touch the Prevention Fund for 2018, and there is $400 million left in 2019, and billions thereafter for the very important programs the gentleman has articulated. We don't use all the money. We leave money behind for these other purposes.

Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

The bottom line is, when you start cutting money from the Prevention Fund, you are cutting prevention programs for kids, adults, the disabled, and, most importantly, the opiates.

CDC spends a significant amount of money from the Prevention Fund dealing with the opiate crisis, so don't tell me that somehow this is okay. You are taking money away from opiate prevention. You are taking money away from kids programs like lead poisoning and vaccines. It is unbelievable how much is actually going to be lost from the Prevention Fund because of this bill.

I am not interested in what happened in the past. I want to know what is going to happen in the future. We have an opiate crisis. Don't take money away from the Prevention Fund that is used to deal with that crisis.

I reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I do think it is important to note that my friend, and he is my friend from New Jersey, has twice voted to use this Prevention Fund for other purposes, including the 2012 middle class tax cut.

I yield 1½ minutes to the gentleman from Texas (Mr. BARTON).

(Mr. BARTON asked and was given permission to revise and extend his remarks.)

Mr. BARTON. Mr. Speaker, we have talked a lot today on the floor about the children's component of this bill, the S–CHIP. It is a good program. It covers about 45 percent of the low-income children in Texas. It is a very worthwhile program and needs to be reauthorized and funded.

I also want to talk about the community health centers. In Ennis, Texas, there is the Nell Barton Hope Clinic Annex. Nell Barton was my mother.

The Joe Barton Family Foundation purchased a building for the Hope Clinic, which is a federally funded health center that is primarily located in Waxahachie, Texas. Every day, several dozen low-income people go to the Nell Barton Hope Clinic. Over the course of the year, several thousand people go to the Hope Clinic in both Ennis and Waxahachie. This bill reauthorizes those health centers for 2 years.

Now, my friends on the Democratic side, I am not sure what they are complaining about. This is a program that funds healthcare for children and for low-income people through the community health centers. It is fully offset, and funding is increasing, Mr. Speaker, not decreasing, but it is doing so in a way that it is offset. What is the big offset?

I hope we vote for this bill when it comes up for a vote later today.

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Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I just wanted to talk about this use of the Prevention Fund. Democrats have never supported the type of drastic cuts to the Prevention Fund that is in this proposal today. In fact, when faced with such cuts, we voted ''no'' nine times. In the two cases where we voted in favor of using some of the Prevention Fund as an offset, neither cut placed the CDC programs and efforts at risk as this legislation does today.

The Republican proposal would cut the Prevention Fund nearly in half and leave a $400 million hole in funding for prevention and health programs within the CDC's budget beginning in 2019. This cut would be devastating to local, State and Federal efforts to protect the Nation's health.

Unlike my Republican counterparts, what they contend, this cut to these programs would not be made up in the annual appropriations process, as evidenced by the proposed cut of $198 million to the CDC in the House Republican fiscal year 2018 appropriations bill, and the decrease of $580 million in CDC funding since 2010 when adjusted for inflation.

Again, you talk about opiates, you talk about children's health programs. These would be drastically cut because of what they are doing today to the Prevention Fund.

Mr. Speaker, I reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, before I yield to the gentleman from Michigan, I would just point out that when Democrats joined Republicans in voting for the 2012 middle class tax cut, we used $6.3 billion out of the Prevention Fund they now say they never touched, yet they have.

Mr. Speaker, I yield 1½ minutes to the gentleman from Michigan (Mr. WALBERG).

Mr. WALBERG. Mr. Speaker, I rise today in support of H.R. 3922. I want to thank Chairman WALDEN and Dr. BURGESS for their leadership in bringing this bill to the floor today.

The CHAMPIONING HEALTHY KIDS Act reauthorizes and funds a number of programs important to my constituents, including the State Children's Health Insurance Program, community health centers, and the Teaching Health Center Graduate Medical Education program.

H.R. 3922 will continue CHIP for 5 years, allowing this successful Federal-State partnership to provide health coverage for low-income children and pregnant women. It also extends funding to federally qualified health centers for 2 years, a key component of the healthcare safety net; and helps address our increasing health provider shortages by investing in the education and training of future health professionals.

Of importance, this legislation is fully paid for with responsible policies, such as measures to allow States to disenroll lottery winners from Medicaid and prioritize the most vulnerable.

I am proud of the good work that was done by the Energy and Commerce Committee to advance this legislation to the floor, and I encourage my colleagues to vote ''yes'' on the bill and to ensure the programs are available for the people who depend upon them.

Mr. PALLONE. Mr. Speaker, I yield 1½ minutes to the gentlewoman from California (Ms. MATSUI).

Ms. MATSUI. Mr. Speaker, I rise in opposition to H.R. 3922.

Mr. Speaker, the uncertainty that we have created for our community health clinics and their patients is unacceptable. Each day it is a new threat. Most

of the year it has been TrumpCare's severe cuts to Medicaid, which health centers and their patients rely upon. Today it is a lack of extension of the critical grant funding. Tomorrow or the next week, we will be back to ripping Medicaid away to pay for the Republican's tax cuts.

We have always extended CHIP and community health center funding on a bipartisan basis, but, unfortunately, the bill before us today is not bipartisan. The Prevention Fund, which would be slashed in this bill, funds programs that are critical to children and families who rely upon CHIP and community health centers. Many times these programs are even run out of our community health centers and could not exist without the Prevention Fund. These are things like childhood asthma prevention, vaccines, and lead abatement.

It often takes someone going above and beyond a simple doctor's visit to provide families with the resources they need to stay healthy. We need to invest in these services. We cannot strip this funding from critical prevention programs that children and families rely on. We cannot allow programs like Medicare and Medicaid to be attacked and raided.

Mr. Speaker, I urge my colleagues to vote ''no'' on H.R. 3922.

Mr. WALDEN. Mr. Speaker, once again, my dear friend from California has twice voted to use these Prevention Funds for other things. By the way, when we use them for community health centers, they are doing this work on the ground, helping people with opioid addictions and other healthcare issues.

Mr. Speaker, I yield 1½ minutes to the gentleman from Georgia (Mr. CARTER).

Mr. CARTER of Georgia. Mr. Speaker, I thank the chairman for yielding and for his outstanding leadership on this very important committee.

Mr. Speaker, I rise today to implore my colleagues to put politics aside for the sake of the 232,000 children in my State of Georgia and the 8.9 million children across our Nation who are counting on us to reauthorize CHIP. Twelve States will run out of CHIP funding before the end of this year. So the idea of waiting around another 2 months before acting on CHIP is simply unacceptable.

Let's be clear why we are here today. Instead of having this discussion 2 months ago, we had to delay the Energy and Commerce Committee markup of the CHAMPIONING HEALTHY KIDS Act, the CHIP bill, because the other side of the aisle refused to even consider reasonable offsets to pay for the program.

I ask my colleagues on the other side of the aisle: How was that objection related to fighting for the middle class?

Even President Obama supported the change for high-income Medicare beneficiaries in his annual budget.

How are we supposed to look parents in the eye back home and tell them that we choose politics instead of choosing to relieve their concerns about coverage?

Mr. Speaker, let's do our job and let's reauthorize CHIP.

Mr. PALLONE. Mr. Speaker, I yield 1½ minutes to gentleman California (Mr. MCNERNEY).

Mr. MCNERNEY. Mr. Speaker, I rise in opposition to H.R. 3922.

Mr. Speaker, it is critical that we authorize CHIP and community health centers, but slashing essential public health funding is not the right way to do it.

Treatment of chronic diseases accounts for 75 percent of our Nation's healthcare spending, and many of these diseases can be prevented. Unfortunately, H.R. 3922 does not do that at all. This bill cuts in half the ACA Prevention and Public Health Fund that plays a critical role in preventing and treating chronic diseases, including keeping kids healthy.

The massive cuts to this funding will be devastating to my Central Valley of California district. My district has the largest number of tuberculosis cases in California for children under 5 years old. Children in this age group are more likely to develop life-threatening forms of TB since their immune systems are less mature. Public officials in my district are relying on funding from the Prevention Fund to address TB outbreaks.

It is troubling that Republicans are using CHIP reauthorization to take core public health services away from kids. It is also frustrating, but not surprising, that the Republicans are making another attempt to sabotage the Affordable Care Act. This legislation is robbing Paul to pay Peter, and I urge my colleagues to vote against it.

Mr. WALDEN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, sabotaging the Affordable Care Act; what we are doing is putting off planned cuts to our hospitals that take care of low-income people that those cuts called for under the Affordable Care Act. We are putting those off so they can serve these low-income people. That, in their language, is sabotaging the Affordable Care Act.

On the issue of using the Prevention Fund, my friend from California who just spoke, has twice voted to use the Prevention Fund, including for tax cuts in 2012 and for the 21st Century Cures Act last year. Now we are using it for community health centers and children's health insurance programs. This is an appropriate use of a fund that gets replenished by law every year.

Mr. Speaker, I yield 1½ minutes to the gentlewoman from Puerto Rico (Miss GONZÁLEZ-COLÓN), whose constituents and herself have suffered such damage, such destruction as a result of the hurricanes.

Miss GONZÁLEZ-COLÓN of Puerto Rico. Mr. Speaker, I rise in strong support of H.R. 3922, the CHAMPIONING HEALTHY KIDS Act.

I wanted to begin by first thanking Chairman WALDEN and Dr. BURGESS for their leadership in moving forward this critically needed legislation. I am particularly thankful for those in the leadership and all of my colleagues in the Energy and Commerce Committee for including a $1 billion allocation to temporarily address Puerto Rico's impending ObamaCare-created medical cliff, while also providing another year of the disproportionate share hospital relief.

To put things in perspective, when we arrived in this Congress during January of this year, more than 1 million Puerto Ricans were facing the imminent possibility of losing their healthcare coverage due to a funding shortfall resulting from ObamaCare's disparate application to the island.

We moved quickly during the appropriations bill, and they allocated $295 million to improve that situation. In this bill, we are allocating $1 billion for Puerto Rico's Medicaid program. This is an important step, but we still need to secure a permanent and equitable solution to Puerto Rico's longstanding Medicaid inequalities, and that means changing the FMAP for the island.

Mr. PALLONE. Mr. Speaker, I yield 1½ minutes to the gentlewoman from New York (Ms. VELÁZQUEZ).

Ms. VELÁZQUEZ. Mr. Speaker, I want to thank the ranking member for yielding.

Mr. Speaker, as Puerto Rico struggles to recover from the historic damage of Hurricane Maria, this legislation shortchanges the island's long-struggling healthcare system at exactly the time that Puerto Rico most needs our help.

This legislation provides a measly sum of Puerto Rico's Medicaid system. Even before Hurricane Maria made landfall, Speaker RYAN had committed to help resolve Puerto Rico's looming Medicaid crisis, yet this bill provides just $1 billion. We have no assurance or guarantee that the next emergency supplemental will provide appropriate funds to address this problem.

The fact is that our fellow citizens have been shortchanged by the disparity in Medicaid funding. This forced the government of Puerto Rico to borrow money to provide healthcare. So if you wonder where Puerto Rico's financial crisis stems from, you can look right here at the U.S. Congress. Yet the amount included in this bill is far from sufficient to address even this year's shortfall. For the Puerto Rican people who have already suffered so much, this funding level amounts to an insult.

If ever there were a time to channel aid to the island's healthcare system and fix the systemic problems that we sought in the system underfunding, this is it.

The SPEAKER pro tempore (Mr. COLLINS of Georgia). The time of the gentlewoman has expired.

Mr. PALLONE. Mr. Speaker, I yield an additional 30 seconds to the gentlewoman from New York.

Ms. VELÁZQUEZ. Mr. Speaker, there are a litany of reasons to oppose this bill, but let's make it clear: one of them is that it will not do enough for the people of Puerto Rico. These are U.S. citizens. They have fought, shed blood, and died in every major conflict. Now they need our help, and this bill does not supply it. Reject this bill. Vote ''no.''

Mr. WALDEN. Mr. Speaker, I yield myself such time as I may consume.

How cynical what we just heard. How cynical.

Ms. VELÁZQUEZ has 43,000 children in CHIP, $2 billion in DSH cuts in her district, 43 health centers, and she is going to vote against $1 billion for the citizens of Puerto Rico and the Virgin Islands because that is not enough.

Yes, we need to do more, so her answer is vote ''no'' today and deny $1 billion.

Mr. Speaker, I yield 1½ minutes to the gentleman from South Carolina (Mr. NORMAN).

Mr. NORMAN. Mr. Speaker, today I rise in support of H.R. 3922. Listening to my Democratic friends, it was said right by Chairman WALDEN. It is cynical, and it is amazing that they could vote against this bill.

Not only does this bill reauthorize public health programs vital to Americans who need them most, but it does so in a fiscally responsible manner. Reauthorizing CHIP for a 5-year period was an important priority of children's healthcare providers in my district, but doing so while saving billions is an impressive feat.

On top of that, providing funding for community health centers will drastically improve rural health in South Carolina's Fifth District. This bill is proof that the American people can trust their government to provide essential services to citizens who cannot provide for themselves, without saddling our children and grandchildren with debt.

Mr. Speaker, I would like to commend my colleague, Chairman WALDEN, for his impressive efforts in striving toward a greater government.

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Mr. PALLONE. Mr. Speaker, I yield 1½ minutes to the gentleman from Massachusetts (Mr. KENNEDY), who is a member of our committee.

Mr. KENNEDY. Mr. Speaker, this moment is a bit hard to stomach. It is hard to stomach yet another attempt to sabotage the Affordable Care Act, in the words of our colleagues, while extolling the virtues of public health programs by cutting grace periods down to 30 days that will result in hundreds of thousands of people losing access to their insurance.

It is hard to stomach a $1 trillion tax cut being proposed for wealthy adults at the same time that our Republican colleagues are telling us that we can't afford to care for sick kids. It is hard to stomach the indifference shown in this Chamber over the course of the past month as CHIP lapses and panic sets in amongst families whose lives depend on this program.

It is hard to stomach an idea that the only way to give them care is to somehow take it away from somebody else, by gutting the Public Health Fund in the midst of an opioid epidemic or scapegoating patients who struggle to afford the monthly premiums and sometimes fall behind.

Why is it always those patients who are asked to sacrifice?

It is always those communities that are asked to do more with less.

Why do we somehow create a false choice on this floor today that leads 9 million families to an impossible choice tomorrow?

For those families, CHIP is not a privilege or a line item in the budget, it is a lifeline. They deserve the same decency and the same urgency that our Republican colleagues showed the wealthy in their tax plan yesterday.

Mr. WALDEN. Mr. Speaker, I yield myself such time as I may consume.

Wow. We are fully funding CHIP for 5 years. We are fully funding our community health centers for 2 years. We are taking care of programs for our citizens who have diabetes. And the pay-for that they are objecting to most is we are asking the wealthiest seniors in America, those making $40,000 a month, to pay $135 more for their Medicare so we can do this work that is so important.

How ironic. How cynical. This is a pay-for that has been used before for other programs. President Obama himself suggested in a budget that, instead of the top earners, the $480,000 a year, a couple making over $800,000 a year pay a little more as we do here, take it all the way down to $80,000 a year.

We didn't do that. We just said, if you are making $480,000 a year, roughly $40,000 a month, you will pay $135 more. They will not vote for that cut to fund children's healthcare. We will.

That is what is going on here. This is where we could never get them off dead center to make this bipartisan. It is a tragedy this is not a bipartisan bill as it always has been. I, three times, delayed moving this forward, including crossing the deadline of September 30, to try to find common ground that would be bipartisan, and we could never get there because they would never yield in a way where we could find common ground.

So we must go to the Senate from here and we must get our work done for the American people.

Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 1½ minutes to gentlewoman from Michigan (Mrs. DINGELL).

Mrs. DINGELL. Mr. Speaker, I rise in strong opposition to this legislation because it presents us with a choice that we should not have to make. I take a backseat to nobody in this institution in terms of fighting for children and families.

But we live in the United States of America, the greatest Nation in the world. I reject the notion that we have to rob Peter to pay Paul or, in this instance, jeopardize the future of Medicare and steal $6 billion from critical prevention programs to pay for children's healthcare. They are all equal priorities, and we shouldn't have to sacrifice the health of one population to pay for another. It is that simple.

The changes that the bill makes to Medicare may sound innocuous—and I have great respect for the chairman—but the reality is they will threaten the future of Medicare.

Means testing Social Security is a good sound bite, but it is a very slippery slope. I'm not worried about whether wealthy families can be able to afford to pay for increased Medicare premiums, but I am worried that these changes will result in wealthy people abandoning the program in large numbers, which would worsen the risk pool and ultimately increase the costs for middle- and lower-income seniors. It would fracture completely the universal nature of Medicare and put the entire program at risk. It is an unwise proposal that should be rejected.

Mr. WALDEN. Mr. Speaker, may I get a time count, please, on how much each side has remaining?

The SPEAKER pro tempore. The gentleman from Oregon has 45 seconds remaining. The gentleman from New Jersey has 4½ minutes remaining.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. Mr. Speaker, the Children's Health Insurance Program began as a truly bipartisan initiative, but now it is being overwhelmed by Republican indifference. So low is it on their priority list that they let the law expire. Three States have already required emergency funding, and 400,000 Texas children are at risk if this program is not continued.

In the face of this crisis, their response is: We won't put another new dollar into this program unless we take it from Medicare beneficiaries.

Why should we begin calling on those who rely on Medicare to pay for non-Medicare purposes?

It is wrong.

The second way they propose to fund this bill is by reducing funding for public health and prevention, whether it is for Zika and West Nile virus, where I live down in Texas, or it is for the opioid crisis, which is affecting our State like every other one.

Sure, we are glad to hear President Trump do a tweet and give a speech. But he did not add any new dollars to fight this opioid crisis. We need bold action, and it is not by reducing the Prevention and Public Health Fund. It is by supporting our children.

Mr. WALDEN. Mr. Speaker, I will just point out that the gentleman who just spoke has voted to cut the Prevention Fund before to use it for other purposes.

Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentlewoman from Michigan (Mrs. LAWRENCE).

Mrs. LAWRENCE. Mr. Speaker, I rise today to support fully funding the CHIP Act, but to oppose to the Republican bill.

Because of the reduction in the grace period, we are forcing Americans to go into their own pocket. Although this bill will reauthorize CHIP, it fails to show compassion for the low-income families and children who do not have access to critical healthcare, and it is a matter of life and death.

CHIP's impact is overwhelmingly felt in communities of color. Together, CHIP and Medicaid help cover 52 percent of Hispanic and 54 percent of all Black children nationwide.

As Members of Congress, we have a duty to protect our Nation's children. We need to support the millions of families who rely on this vital program. This is not the right way. We need to work together in a bipartisan manner to pass an important piece of legislation like CHIP and not take away from our children but support them.

Mr. PALLONE. Mr. Speaker, how much time remains on each side?

The SPEAKER pro tempore. The gentleman from New Jersey has 2½ minutes remaining. The gentleman from Oregon has 45 seconds remaining.

Mr. PALLONE. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, I want to stress again that one of the pay-fors that the Republicans don't talk about much is the fact that they are reducing the grace period from 90 days to 30 days. So if someone misses a payment on their insurance, they currently have 90 days to make up for it. Under this bill, they will only have 30 days.

Now, the CBO estimates that over 500,000 people will lose their health insurance and have to reapply for next year because of this reduction in the grace period. I know my colleague from the other side says: Well, that is too bad because they have the responsibility to pay it.

But the fact of the matter is that a lot of people have a hard time paying their monthly premium, and we should not be passing legislation that ends up with half-a-million people losing their health insurance.

Again, this is a way to sabotage the Affordable Care Act. The Affordable Care Act is trying to make more people covered, and has succeeded in covering 95 percent of the people in this country.

Why in the world would we use a pay-for that cuts back on half-a-million people who would lose their health insurance?

I want to emphasize, Mr. Speaker, we did not have to be here today. We could have done a bipartisan bill without sabotaging the Affordable Care Act. That is what concerns me most, Mr. Speaker. The Republicans tried to repeal the Affordable Care Act. They failed, and now they are trying to repeal it piece by piece.

The pay-fors that are in this legislation are unfair to the American people. The Prevention Fund is used for opiate prevention and used for kids for various programs. Don't cut back on that to pay for these other things.

The grace period—half-a-million Americans are going to lose their insurance because of the cutbacks in the grace period—another effort to sabotage the Affordable Care Act.

Lastly, and probably even most important, again, the Republicans are going against the Medicare program. They are trying to make cuts in the Medicare program and restructure the Medicare program in a way that I believe will hurt the Medicare program, reduce the amount of people in the insurance pool, and ultimately lead to higher costs for middle class and lower-income seniors and the disabled in the Medicare program.

I urge my colleagues: Don't let the Republicans continue to sabotage the Affordable Care Act. We could have done this on a bipartisan basis. Passing this bill today does nothing for the Children's Health Initiative or for community health centers because this bill is going nowhere. It will end up in the Senate. The Senate will not take it up, and we will be waiting around until Christmas to actually find a way to fund these programs and put these programs at risk. Vote ''no.''

Mr. Speaker, I yield back the balance of my time.

Mr. WALDEN. Mr. Speaker, let's get this back where it belongs. We are fully funding the Children's Health Insurance Program for 5 years and community health centers for 2 years. The only sabotage of the Affordable Care Act going on here today is stopping cuts for hospitals in our districts that serve low-income people that would otherwise occur under the Affordable Care Act. We do that for 2 years.

The Democrats don't think seniors making $40,000 a month—$40,000 a month—should pay an extra $135 for their part B and part D Medicare so we can take care of our community health centers and children who need health insurance.

We delayed this bill coming to the floor at a bipartisan request to find a bipartisan solution that was elusive, sadly. We have never had this problem before, but we have it today. We must act.

Mr. Speaker, I urge a ''yes'' vote on this legislation, and I yield back the balance of my time.

Ms. MCCOLLUM. Mr. Speaker, I rise in opposition to the Community Health and Medical Professionals Improve Our Nation (CHAMPION) Act of 2017 (H.R. 3922).

While I support reauthorizing funding for the Children's Health Insurance Program (CHIP), the Federally Qualified Health Centers (FQHCs), and various other important public health programs, I oppose this bill because it cuts funding for public health, puts families at risk of losing their health insurance, and weakens Medicare.

The health of children and expecting and new mothers is something that we can all agree on. In my home state of Minnesota, CHIP funding is essential for providing healthcare to 125,000 low income children and 1,700 expecting and new mothers. Minnesota also depends on FQHC funding with over 190,000 people receiving care from one of the more than 70 community health centers in my state last year.

Unfortunately, House Republicans have turned these bipartisan issues into an opportunity to divide us. The offsets included in this legislation are unacceptable to me and to Minnesota families.

Once again, Republicans are using this legislation as yet another opportunity to weaken the Affordable Care Act (ACA) by cutting $6.35 billion from the Prevention and Public Health Fund over the next ten years. This fund, created by the ACA, directly funds our nation's prevention, preparedness, and response capabilities.

If these Republican cuts become law, the Centers for Disease Control and Prevention would be forced to provide less funding to cities, states, and tribes to rapidly address public health crises. This money includes funding for vaccines, flu prevention, and addressing the opioid epidemic. When my home state of Minnesota had to recently deal with a serious outbreak of measles, our community health officials utilized these federal resources to rapidly contain the spread of disease. Simply put, this irresponsible offset leaves American communities more vulnerable to, and unprepared for, outbreaks of disease.

In addition, this bill takes aim at yet another ACA provision by shortening the 90-day grace period for individuals to pay premiums before their insurer can terminate their coverage. The current grace period allows low and moderate income families experiencing temporary financial difficulties to remain covered by their health insurance. Shortening this grace period from 90 days to 30 days would cause nearly 700,000 Americans to lose their health care and bars them from purchasing health insurance until the next season.

I am also concerned by the provision that introduces means testing to Medicare. A key strength of Medicare is its universal nature. All Americans pay into Medicare and all Americans should receive at least some benefit from it. This provision breaks that guarantee and sets a dangerous precedent for the future. I am also concerned that it could weaken the Medicare risk pool and increase costs for the taxpayer.

Mr. Speaker, even the Majority concedes that this bill is unlikely to pass the Senate due to the partisan nature of its provisions. Republicans need to stop playing games and reauthorize these programs before Minnesota faces a critical December 1 deadline to continue coverage for children and expecting mothers.

I urge my colleagues to vote against this measure and instead to work together to fund CHIP and community health centers.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise today in strong opposition to the bill being considered on the floor today, H.R. 3922, the CHAMPIONING HEALTHY KIDS Act. Unfortunately, this deceitfully named measure to reauthorize the Children's Health

Insurance Program (CHIP) and Community Health Centers (CHCs) will reauthorize these programs through FY19—but does so by kicking thousands of Americans off private insurance.

Like many of my colleagues, I strongly support CHIP, CHCs, and other critical public health initiatives. However, the bill in its current form was drafted as yet another attempt by Republicans to undermine the Affordable Care Act in order to justify its repeal. The bill is misguided in its attempt to cut $6.35 billion over ten years from the Prevention and Public Health Fund in order to fund the extension.

H.R. 3922 also reduces grace periods from 90 to 30 days, putting more than 688,000 low- and moderate-income individuals at risk of losing their state Marketplace coverage for simply paying their premiums in the second of third month of the existing grace period. This grace period is essential to low-income households that are barely making ends meet. By reducing the current grace period, Republicans are exposing thousands of families to risk due to a lack of health coverage. It is frankly disgraceful that we would even consider undermining these important public health programs in such a manner.

Mr. Speaker, CHIP, CHCs, the National Health Service Corps, and other programs funded under this measure are vitally important to our nation and the public health of our citizens. As the first registered nurse elected to Congress, I understand the critical need for proper long-term funding of our public health centers and programs. However, these cuts to the Prevention and Public Health Fund represent a purely political move by the GOP to undermine the ACA. I oppose this controversial offset, not my support for health centers across America. I urge my colleagues to oppose this measure so that we can find offsets driven by policy, not politics, in order to sufficiently fund our health centers and promote public health for all.

Ms. JACKSON LEE. Mr. Speaker, I rise to speak on House consideration of H.R. 3922, Championing Healthy Kids Act, which would reauthorize the State Children Health Insurance Program (S–CHIP).

As the founder and chair of the Congressional Children's Caucus, I am well aware of the work that went into creating this important program.

I joined with members of the bipartisan Children's Caucus to champion the worthy goals of S–CHIP.

Congress and President Clinton responded to the needs of 10 million children in the United States who lacked health insurance, S–CHIP was created in 1997 to insure children in families with too much income to qualify for Medicaid and too little to afford private insurance.

I voted for the S–CHIP program when it came to the floor for a vote as part of the Balanced Budget Act of 1997.

I worked tirelessly along with other members of the House to make sure the S–CHIP program was created.

I voted to extend the life of the program when Congress reauthorized S–CHIP in 2009 under the Children's Health Insurance Program Reauthorization Act and again when it became part of the Patient Protection and Affordable Care Act of 2010.

The program represented a grand bargain that allowed Democrats and Republicans to agree that healthcare for the nation's children was a laudable and achievable goal.

H.R. 3922, Championing Healthy Kids Act, is not a reauthorization of the S–CHIP program it is political theater at its worse.

The leadership of the House is betraying all that this body has done for 20 years to sustain and improve S–CHIP.

The bill before the House is political theater and not real legislating—a partisan attack against Medicare that has no place in a real bill about healthcare for children.

I am a strong supporter of S–CHIP and would vote for that program any day it is brought to the House Floor.

This imposter S–CHIP bill is not worthy to be considered by this body.

The motion to recommit this bill should be supported so that the offensive offsets could be removed so that the bill can be brought back to the full House for consideration.

After weeks of negotiations to reauthorize the Children's Health Insurance Program (CHIP), Community Health Centers (CHCs) and other important public health programs, which have always been bipartisan priorities, House Republicans have decided to bring a partisan bill to the Floor.

This bill will only further delay the reauthorization of these programs, many of which expired on September 30th.

The bill passed out of the Energy and Commerce Committee at the beginning of October with no Democratic support.

Democrats in Committee instead offered a package that invests in our children and safety net providers, and does not sacrifice the nation's health.

Democrats have made it clear for weeks that the pay-fors in this bill are problematic.

Rather than working toward a bipartisan agreement, Republicans revised their bill to include even steeper cuts to public health programs, in addition to undermining the Affordable Care Act (ACA).

The bill includes woefully inadequate funding for Medicaid programs in Puerto Rico and the U.S. Virgin Islands, which are facing unprecedented demands on their health care systems following the devastation caused by Hurricane Maria.

Puerto Rico Governor Ricardo Rossello last week requested $1.6 billion annually to deal with the state's underfunded Medicaid program that is expected to be further strained by the short- and long-term health implications of the natural disaster.

The approximately $1 billion over two years in Puerto Rico Medicaid funding included in the Republican bill is not only insufficient, but it would also require Puerto Rico and the U.S. Virgin Islands to match those dollars at a time of increased demand and revenue collapse in both territories, exacerbating delays in recovery.

This bill also seeks to cut $6.35 billion to the Prevention and Public Health Fund (PPHF).

The Prevention Fund was created by the ACA to make national investments in prevention and public health, to improve health outcomes, to enhance health care quality, and reduce health care costs.

It has been used to increase awareness of and access to preventive health services, such as cancer screenings, tobacco cessation and childhood vaccines—as well as concentrating on preventing chronic disease to help more Americans stay healthy.

Cutting these funds will have a devastating impact on public health initiatives at the federal, state and local levels.

Republicans are also shortening the grace period for missed premium payments from ninety days to thirty, which would result in up to 688,000 people losing health coverage.

House Republicans are insisting that in order to provide some of our most vulnerable Americans with coverage, it must be paid for by cancelling the health insurance of other Americans after a single payment is missed.

While Republicans are pushing for tax cuts for the wealthy that explode the deficit, when it comes to health coverage for children and low-income Americans, Republicans are insisting that it be paid for at the cost of weakening our health care system and pushing other Americans off health insurance.

States have begun to use emergency funding, cut benefits, and will soon begin sending disenrollment notices to thousands of families if CHIP is not reauthorized.

Republicans' decision to advance a partisan bill rather than a compromise has very real consequences for families across the country.

In 2016, 35,626,329 children in the United States had healthcare coverage under S–CHIP or the Medicaid Child Program.

In 2016, although the state of Texas had 38 percent of our children covered under the S–CHIP program, there were still 9.2 percent children without health insurance coverage.

Paying for this package by weakening health care in America:

Shortening the grace period for missed premium payments will cause up to 688,000 Americans to lose their health coverage.

Cutting $6.35 billion from the Prevention Fund will have a devastating impact on public health initiatives at the federal, state and local levels.

Requiring Medicare means testing of 100 percent for beneficiaries making over $500,000. This provision will take away a benefit American seniors have paid into their entire lives.

These offsets are even more egregious since they are being considered just one week after House Republicans began the process of passing tax cuts for the wealthy that is not offset and will add $1.5 trillion to the deficit.

Instead of reauthorizing these programs, House Republicans wasted time attempting to repeal the ACA.

There are better ways to pay for S–CHIP that do not put the guarantee of Medicare at risk our nation's seniors.

1. Reduce tax expenditures for the top 1 percent of income-earners—Our current tax code imposes higher tax rates on income earned through hard work while providing preferential treatment to unearned financial gains and allowing billions of dollars of stock profits and other capital gains to pass tax-free to heirs of multi-million-dollar fortunes. Reducing the benefit of these tax expenditures would help rebalance the tax code so that it stops favoring wealth over work. CBO has determined that 17 percent of the benefits of major ''tax expenditures'' go to households in the top one percent of income earners at a cost of more than $1.5 trillion over ten years. We could reduce this benefit to pay for needed national priorities.

2. Cancel the tax break for corporate jets—Repeal tax breaks such as those for corporate jets, which are allowed a faster depreciation

schedule than passenger and freight aircraft. Based on past Joint Committee on Taxation estimates, repealing the tax break on corporate jets alone would raise $3 billion over ten years.

3. Restrict deductions for egregious CEO bonuses when employees don't get a raise—Repeal the exemption to the $1 million limit on compensation for CEOs and other specified corporate employees that a publicly traded corporation can deduct as a business expense, unless their workers are getting paycheck increases that reflect increases in worker productivity and the cost of living. Based on Joint Committee on Taxation estimates, just limiting the deductibility of excessive CEO compensation would raise $12 billion over ten years.

4. Close loopholes in the U.S. international corporate tax system that encourage companies to invert, and ship jobs and profits overseas—Prevent U.S. companies from ''inverting'' and pretending that they are based in other countries purely to reduce their taxes. Enact proposals that would limit the ability of corporations to reap substantial tax benefits by shifting operations, capital, intellectual property, and jobs overseas for tax purposes or to shelter their profits from U.S. taxation in foreign tax havens. Based on estimates of past proposals, over $500 billion over ten years could be raised under such proposals.

5. Close the ''carried interest'' loophole taxing hedge fund managers' compensation at lower capital gains rates—End the loophole which allows certain investment managers at hedge funds and private equity firms to pay capital gains tax rates (up to a maximum of just 20 percent) on income received as compensation for services they provided, rather than ordinary income tax rates up to 39.6 percent that all other working Americans pay on the compensation they receive for their labor. Past estimates show closing this loophole would raise over $19 billion over ten years.

States have begun to use emergency funding, cut benefits, and will soon begin sending disenrollment notices to thousands of families if CHIP is not reauthorized.

It is time for the House Leadership to stop playing politics with health insurance coverage for our nation's most vulnerable children and pass a clean S–CHIP bill.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 601, the previous question is ordered on the bill, as amended.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT

Mr. CLYBURN. Mr. Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. CLYBURN. I am opposed in its current form.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Clyburn moves to recommit the bill H.R. 3922 to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendment:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Continuing Community Health and Medical Professional Programs to Improve Our Nation and Keep Insurance Delivery Stable Act of 2017'' or the ''CHAMPION KIDS Act of 2017''.

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

TITLE I—MEDICAID AND PUBLIC HEALTH EXTENDERS

SEC. 101. EXTENSION FOR COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS.

(a) COMMUNITY HEALTH CENTERS FUNDING.—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 ''2017'' and inserting ''2019''.

(b) OTHER COMMUNITY HEALTH CENTERS PROVISIONS.—Section 330 of the Public Health Service Act (42 U.S.C. 254b) is amended—

(1) in subsection (b)(1)(A)(ii), by striking ''abuse'' and inserting ''use disorder'';

(2) in subsection (b)(2)(A), by striking ''abuse'' and inserting ''use disorder'';

(3) in subsection (c)—

(A) in paragraph (1), by striking subparagraphs (B) through (D);

(B) by striking ''(1) IN GENERAL'' and all that follows through ''The Secretary'' and inserting the following:

''(1) CENTERS.—The Secretary''; and

(C) in paragraph (1), as amended, by redesignating clauses (i) through (v) as subparagraphs (A) through (E) and moving the margin of each of such redesignated subparagraph 2 ems to the left;

(4) by striking subsection (d) and inserting the following:

''(d) IMPROVING QUALITY OF CARE.—

''(1) SUPPLEMENTAL AWARDS.—The Secretary may award supplemental grant funds to health centers funded under this section to implement evidence-based models for increasing access to high-quality primary care services, which may include models related to—

''(A) improving the delivery of care for individuals with multiple chronic conditions;

''(B) workforce configuration;

''(C) reducing the cost of care;

''(D) enhancing care coordination;

''(E) expanding the use of telehealth and technology-enabled collaborative learning and capacity building models;

''(F) care integration, including integration of behavioral health, mental health, or substance use disorder services; and

''(G) addressing emerging public health or substance use disorder issues to meet the health needs of the population served by the health center.

''(2) SUSTAINABILITY.—In making supplemental awards under this subsection, the Secretary may consider whether the health center involved has submitted a plan for continuing the activities funded under this subsection after supplemental funding is expended.

''(3) SPECIAL CONSIDERATION.—The Secretary may give special consideration to applications for supplemental funding under this subsection that seek to address significant barriers to access to care in areas with a greater shortage of health care providers and health services relative to the national average.'';

(5) in subsection (e)(1)—

(A) in subparagraph (B)—

(i) by striking ''2 years'' and inserting ''1 year''; and

(ii) by adding at the end the following: ''The Secretary shall not make a grant under this paragraph unless the applicant provides assurances to the Secretary that within 120 days of receiving grant funding for the operation of the health center, the applicant will submit, for approval by the Secretary, an implementation plan to meet the requirements of subsection (l)(3). The Secretary may extend such 120-day period for achieving compliance upon a demonstration of good cause by the health center.''; and

(B) in subparagraph (C)—

(i) in the subparagraph heading, by striking ''AND PLANS'';

(ii) by striking ''or plan (as described in subparagraphs (B) and (C) of subsection (c)(1))'';

(iii) by striking ''or plan, including the purchase'' and inserting the following: ''including—

''(i) the purchase'';

(iv) by inserting '', which may include data and information systems'' after ''of equipment'';

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

(vi) by adding at the end the following:

''(ii) the provision of training and technical assistance; and

''(iii) other activities that—

''(I) reduce costs associated with the provision of health services;

''(II) improve access to, and availability of, health services provided to individuals served by the centers;

''(III) enhance the quality and coordination of health services; or

''(IV) improve the health status of communities.'';

(6) in subsection (e)(5)(B)—

(A) in the heading of subparagraph (B), by striking ''AND PLANS''; and

(B) by striking ''and subparagraphs (B) and (C) of subsection (c)(1) to a health center or

to a network or plan'' and inserting ''to a health center or to a network'';

(7) by striking subsection (s);

(8) by redesignating subsections (g) through (r) as subsections (h) through (s), respectively;

(9) by inserting after subsection (f), the following:

''(g) NEW ACCESS POINTS AND EXPANDED SERVICES.—

''(1) APPROVAL OF NEW ACCESS POINTS.—

''(A) IN GENERAL.—The Secretary may approve applications for grants under subparagraph (A) or (B) of subsection (e)(1) to establish new delivery sites.

''(B) SPECIAL CONSIDERATION.—In carrying out subparagraph (A), the Secretary may give special consideration to applicants that have demonstrated the new delivery site will be located within a sparsely populated area, or an area which has a level of unmet need that is higher relative to other applicants.

''(C) CONSIDERATION OF APPLICATIONS.—In carrying out subparagraph (A), the Secretary shall approve applications for grants under subparagraphs (A) and (B) of subsection (e)(1) in such a manner that the ratio of the medically underserved populations in rural areas which may be expected to use the services provided by the applicants involved to the medically underserved populations in urban areas which may be expected to use the services provided by the applicants is not less than two to three or greater than three to two.

''(D) SERVICE AREA OVERLAP.—If in carrying out subparagraph (A) the applicant proposes to serve an area that is currently served by another health center funded under this section, the Secretary may consider whether the award of funding to an additional health center in the area can be justified based on the unmet need for additional services within the catchment area.

''(2) APPROVAL OF EXPANDED SERVICE APPLICATIONS.—

''(A) IN GENERAL.—The Secretary may approve applications for grants under subparagraph (A) or (B) of subsection (e)(1) to expand the capacity of the applicant to provide required primary health services described in subsection (b)(1) or additional health services described in subsection (b)(2).

''(B) PRIORITY EXPANSION PROJECTS.—In carrying out subparagraph (A), the Secretary may give special consideration to expanded service applications that seek to address emerging public health or behavioral health, mental health, or substance abuse issues through increasing the availability of additional health services described in subsection (b)(2) in an area in which there are significant barriers to accessing care.

''(C) CONSIDERATION OF APPLICATIONS.—In carrying out subparagraph (A), the Secretary shall approve applications for applicants in such a manner that the ratio of the medically underserved populations in rural areas which may be expected to use the services provided by the applicants involved to the medically underserved populations in urban areas which may be expected to use the services provided by such applicants is not less than two to three or greater than three to two.'';

(10) in subsection (i) (as so redesignated)—

(A) in paragraph (1), by striking ''and children and youth at risk of homelessness'' and inserting '', children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness''; and

(B) in paragraph (5)—

(i) by striking subparagraph (B);

(ii) by redesignating subparagraph (C) as subparagraph (B); and

(iii) in subparagraph (B) (as so redesignated)—

(I) in the subparagraph heading, by striking ''ABUSE'' and inserting ''USE DISORDER''; and

(II) by striking ''abuse'' and inserting ''use disorder'';

(11) in subsection (l) (as so redesignated)—

(A) in paragraph (2)—

(i) in the paragraph heading, by inserting ''UNMET'' before ''NEED'';

(ii) in the matter preceding subparagraph (A), by inserting ''and an application for a grant under subsection (g)'' after ''subsection (e)(1)'';

(iii) in subparagraph (A), by inserting ''unmet'' before ''need for health services'';

(iv) in subparagraph (B), by striking ''and'' at the end;

(v) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

(vi) by adding after subparagraph (C) the following:

''(D) in the case of an application for a grant pursuant to subsection (g)(1), a demonstration that the applicant has consulted with appropriate State and local government agencies, and health care providers regarding the need for the health services to be provided at the proposed delivery site.'';

(B) in paragraph (3)—

(i) in the matter preceding subparagraph (A), by inserting ''or subsection (g)'' after ''subsection (e)(1)(B)'';

(ii) in subparagraph (B), by striking ''in the catchment area of the center'' and inserting '', including other health care providers that provide care within the catchment area, local hospitals, and specialty providers in the catchment area of the center, to provide access to services not available through the health center and to reduce the non-urgent use of hospital emergency departments'';

(iii) in subparagraph (H)(ii), by inserting ''who shall be directly employed by the center'' after ''approves the selection of a director for the center'';

(iv) in subparagraph (L), by striking ''and'' at the end;

(v) in subparagraph (M), by striking the period and inserting ''; and''; and

(vi) by inserting after subparagraph (M), the following:

''(N) the center has written policies and procedures in place to ensure the appropriate use of Federal funds in compliance with applicable Federal statutes, regulations, and the terms and conditions of the Federal award.''; and

(C) by striking paragraph (4);

(12) in subsection (m) (as so redesignated), by adding at the end the following: ''Funds expended to carry out activities under this subsection and operational support activities under subsection (n) shall not exceed 3 percent of the amount appropriated for this section for the fiscal year involved.'';

(13) in subsection (q) (as so redesignated), by striking ''grants for new health centers under subsections (c) and (e)'' and inserting ''operating grants under subsection (e), applications for new access points and expanded service pursuant to subsection (g)'';

(14) in subsection (r)(4) (as so redesignated), by adding at the end the following: ''A waiver provided by the Secretary under this paragraph may not remain in effect for more than 1 year and may not be extended after such period. An entity may not receive more than one waiver under this paragraph in consecutive years.'';

(15) in subsection (s)(3) (as so redesignated)—

(A) by striking ''appropriate committees of Congress a report concerning the distribution of funds under this section'' and inserting the following: ''Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce of the House of Representatives, a report including, at a minimum—

''(A) the distribution of funds for carrying out this section'';

(B) by striking ''populations. Such report shall include an assessment'' and inserting the following: ''populations;

''(B) an assessment'';

(C) by striking ''and the rationale for any substantial changes in the distribution of funds.'' and inserting a semicolon; and

(D) by adding at the end the following:

''(C) the distribution of awards and funding for new or expanded services in each of rural areas and urban areas;

''(D) the distribution of awards and funding for establishing new access points, and the number of new access points created;

''(E) the amount of unexpended funding for loan guarantees and loan guarantee authority under title XVI;

''(F) the rationale for any substantial changes in the distribution of funds;

''(G) the rate of closures for health centers and access points;

''(H) the number and reason for any grants awarded pursuant to subsection (e)(1)(B); and

''(I) the number and reason for any waivers provided pursuant to subsection (r)(4).''; and

(16) in subsection (s) (as so redesignated) by adding at the end the following new paragraph:

''(5) FUNDING FOR PARTICIPATION OF HEALTH CENTERS IN ALL OF US RESEARCH PROGRAM.—In addition to any amounts made available pursuant to paragraph (1) of this subsection, section 402A of this Act, or section 10503 of the Patient Protection and Affordable Care Act, there is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, to the Secretary $25,000,000 for fiscal year 2018 to support the participation of health centers in the All of Us Research Program under the Precision Medicine Initiative under section 498E of this Act.''.

(c) 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 ''2017'' and inserting ''2019''.

(d) CONFORMING AMENDMENT.—Section 3014(h)(1) of title 18, United States Code, is amended by striking '', as amended by section 221 of the Medicare Access and CHIP Reauthorization Act of 2015,''.

SEC. 102. EXTENSION FOR SPECIAL DIABETES PROGRAMS.

(a) SPECIAL DIABETES PROGRAM FOR TYPE I DIABETES.—Section 330B(b)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)(C)) is amended by striking ''2017'' and inserting ''2019''.

(b) SPECIAL DIABETES PROGRAM FOR INDIANS.—Section 330C(c)(2) of the Public Health Service Act (42 U.S.C. 254c–3(c)(2)) is amended—

(1) in subparagraph (C), by striking ''and'' at the end;

(2) in subparagraph (D), by striking the period at the end and inserting ''and $112,500,000 for the period consisting of the second, third, and fourth quarters of fiscal year 2018; and''; and

(3) by adding at the end the following:

''(E) $150,000,000 for fiscal year 2019.''.

SEC. 103. REAUTHORIZATION OF PROGRAM OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

(a) PAYMENTS.—Subsection (a) of section 340H of the Public Health Service Act (42 U.S.C. 256h) is amended to read as follows:

''(a) PAYMENTS.—

''(1) IN GENERAL.—Subject to subsection (h)(2), the Secretary shall make payments under this section for direct expenses and indirect expenses to qualified teaching health

centers that are listed as sponsoring institutions by the relevant accrediting body for—

''(A) maintenance of existing approved graduate medical residency training programs;

''(B) expansion of existing approved graduate medical residency training programs; and

''(C) establishment of new approved graduate medical residency training programs, as appropriate.

''(2) PRIORITY.—In making payments pursuant to paragraph (1)(C), the Secretary shall give priority to qualified teaching health centers that—

''(A) serve a health professional shortage area with a designation in effect under section 332 or a medically underserved community (as defined in section 799B); or

''(B) are located in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act).''.

(b) FUNDING.—Subsection (g) of section 340H of the Public Health Service Act (42 U.S.C. 256h) is amended—

(1) by striking ''To carry out'' and inserting the following:

''(1) IN GENERAL.—To carry out'';

(2) by striking ''and $15,000,000 for the first quarter of fiscal year 2018'' and inserting '', $15,000,000 for the first quarter of fiscal year 2018, $111,500,000 for the period consisting of the second, third, and fourth quarters of fiscal year 2018, and $126,500,000 for fiscal year 2019, to remain available until expended''; and

(3) by adding at the end the following:

''(2) ADMINISTRATIVE EXPENSES.—Of the amount made available to carry out this section for any fiscal year, the Secretary may not use more than 5 percent of such amount for the expenses of administering this section.''.

(c) ANNUAL REPORTING.—Subsection (h)(1) of section 340H of the Public Health Service Act (42 U.S.C. 256h) is amended—

(1) by redesignating subparagraph (D) as subparagraph (H); and

(2) by inserting after subparagraph (C) the following:

''(D) The number of patients treated by residents described in paragraph (4).

''(E) The number of visits by patients treated by residents described in paragraph (4).

''(F) Of the number of residents described in paragraph (4) who completed their residency training at the end of such residency academic year, the number and percentage of such residents entering primary care practice (meaning any of the areas of practice listed in the definition of a primary care residency program in section 749A).

''(G) Of the number of residents described in paragraph (4) who completed their residency training at the end of such residency academic year, the number and percentage of such residents who entered practice at a health care facility—

''(i) primarily serving a health professional shortage area with a designation in effect under section 332 or a medically underserved community (as defined in section 799B); or

''(ii) located in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act).''.

(d) REPORT ON TRAINING COSTS.—Not later than March 31, 2019, the Secretary of Health and Human Services shall submit to the Congress a report on the direct graduate expenses of approved graduate medical residency training programs, and the indirect expenses associated with the additional costs of teaching residents, of qualified teaching health centers (as such terms are used or defined in section 340H of the Public Health Service Act (42 U.S.C. 256h)).

(e) DEFINITION.—Subsection (j) of section 340H of the Public Health Service Act (42 U.S.C. 256h) is amended—

(1) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively; and

(2) by inserting after paragraph (1) the following:

''(2) NEW APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'new approved graduate medical residency training program' means an approved graduate medical residency training program for which the sponsoring qualified teaching health center has not received a payment under this section for a previous fiscal year (other than pursuant to subsection (a)(1)(C)).''.

(f) TECHNICAL CORRECTION.—Subsection (f) of section 340H (42 U.S.C. 256h) is amended by striking ''hospital'' each place it appears and inserting ''teaching health center''.

(g) PAYMENTS FOR PREVIOUS FISCAL YEARS.—The provisions of section 340H of the Public Health Service Act (42 U.S.C. 256h), as in effect on the day before the date of enactment of this Act, shall continue to apply with respect to payments under such section for fiscal years before fiscal year 2018.

SEC. 104. EXTENSION FOR FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

Section 501(c) of the Social Security Act (42 U.S.C. 701(c)) is amended—

(1) in paragraph (1)(A)—

(A) in clause (v), by striking ''and'' at the end;

(B) in clause (vi), by striking the period at the end and inserting ''; and''; and

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

''(vii) $6,000,000 for each of fiscal years 2018 and 2019.'';

(2) in paragraph (3)(C), by inserting before the period the following: '', and with respect to fiscal years 2018 and 2019, such centers shall also be developed in all territories and at least one such center shall be developed for Indian tribes''; and

(3) by amending paragraph (5) to read as follows:

''(5) For purposes of this subsection—

''(A) the term 'Indian tribe' has the meaning given such term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603);

''(B) the term 'State' means each of the 50 States and the District of Columbia; and

''(C) the term 'territory' means Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Northern Mariana Islands.''.

SEC. 105. YOUTH EMPOWERMENT PROGRAM; PERSONAL RESPONSIBILITY EDUCATION.

(a) YOUTH EMPOWERMENT PROGRAM.—

(1) IN GENERAL.—Section 510 of the Social Security Act (42 U.S.C. 710) is amended to read as follows:

''SEC. 510. YOUTH EMPOWERMENT PROGRAM.

''(a) IN GENERAL.—

''(1) ALLOTMENTS TO STATES.—For the purpose described in subsection (b), the Secretary shall, for each of fiscal years 2018 and 2019, allot to each State which has transmitted an application for the fiscal year under section 505(a) an amount equal to the product of—

''(A) the amount appropriated pursuant to subsection (e)(1) for the fiscal year, minus the amount reserved under subsection (e)(2) for the fiscal year; and

''(B) the proportion that the number of low-income children in the State bears to the total of such numbers of children for all the States.

''(2) OTHER ALLOTMENTS.—

''(A) OTHER ENTITIES.—For the purpose described in subsection (b), the Secretary shall, for each of fiscal years 2018 and 2019, for any State which has not transmitted an application for the fiscal year under section 505(a), allot to one or more entities in the State the amount that would have been allotted to the State under paragraph (1) if the State had submitted such an application.

''(B) PROCESS.—The Secretary shall select the recipients of allotments under subparagraph (A) by means of a competitive grant process under which—

''(i) not later than 30 days after the deadline for the State involved to submit an application for the fiscal year under section 505(a), the Secretary publishes a notice soliciting grant applications; and

''(ii) not later than 120 days after such deadline, all such applications must be submitted.

''(b) PURPOSE.—

''(1) IN GENERAL.—Except for research under paragraph (5) and information collection and reporting under paragraph (6), the purpose of an allotment under subsection (a) to a State (or to another entity in the State pursuant to subsection (a)(2)) is to enable the State or other entity to implement education exclusively on sexual risk avoidance (meaning voluntarily refraining from sexual activity).

''(2) REQUIRED COMPONENTS.—Education on sexual risk avoidance pursuant to an allotment under this section shall—

''(A) ensure that the unambiguous and primary emphasis and context for each topic described in paragraph (3) is a message to youth that normalizes the optimal health behavior of avoiding nonmarital sexual activity;

''(B) be medically accurate and complete;

''(C) be age-appropriate; and

''(D) be based on adolescent learning and developmental theories for the age group receiving the education.

''(3) TOPICS.—Education on sexual risk avoidance pursuant to an allotment under this section shall address each of the following topics:

''(A) The holistic individual and societal benefits associated with personal responsibility, self-regulation, goal setting, healthy decisionmaking, and a focus on the future.

''(B) The advantage of refraining from nonmarital sexual activity in order to improve the future prospects and physical and emotional health of youth.

''(C) The increased likelihood of avoiding poverty when youth attain self-sufficiency and emotional maturity before engaging in sexual activity.

''(D) The foundational components of healthy relationships and their impact on the formation of healthy marriages and safe and stable families.

''(E) How other youth risk behaviors, such as drug and alcohol usage, increase the risk for teen sex.

''(F) How to resist and avoid, and receive help regarding, sexual coercion and dating violence, recognizing that even with consent teen sex remains a youth risk behavior.

''(4) CONTRACEPTION.—Education on sexual risk avoidance pursuant to an allotment under this section shall ensure that—

''(A) any information provided on contraception is medically accurate and ensures that students understand that contraception offers physical risk reduction, but not risk elimination; and

''(B) the education does not include demonstrations, simulations, or distribution of contraceptive devices.

''(5) RESEARCH.—

''(A) IN GENERAL.—A State or other entity receiving an allotment pursuant to subsection (a) may use up to 20 percent of such allotment to build the evidence base for sexual risk avoidance education by conducting or supporting research.

''(B) REQUIREMENTS.—Any research conducted or supported pursuant to subparagraph (A) shall be—

''(i) rigorous;

''(ii) evidence-based; and

''(iii) designed and conducted by independent researchers who have experience in conducting and publishing research in peer-reviewed outlets.

''(6) INFORMATION COLLECTION AND REPORTING.—A State or other entity receiving an allotment pursuant to subsection (a) shall, as specified by the Secretary—

''(A) collect information on the programs and activities funded through the allotment; and

''(B) submit reports to the Secretary on the data from such programs and activities.

''(c) NATIONAL EVALUATION.—

''(1) IN GENERAL.—The Secretary shall—

''(A) in consultation with appropriate State and local agencies, conduct one or more rigorous evaluations of the education funded through this section and associated data; and

''(B) submit a report to the Congress on the results of such evaluations, together with a summary of the information collected pursuant to subsection (b)(6).

''(2) CONSULTATION.—In conducting the evaluations required by paragraph (1), including the establishment of evaluation methodologies, the Secretary shall consult with relevant stakeholders.

''(d) APPLICABILITY OF CERTAIN PROVISIONS.—

''(1) Sections 503, 507, and 508 apply to allotments under subsection (a) to the same extent and in the same manner as such sections apply to allotments under section 502(c).

''(2) Sections 505 and 506 apply to allotments under subsection (a) to the extent determined by the Secretary to be appropriate.

''(e) FUNDING.—

''(1) IN GENERAL.—To carry out this section, there is appropriated, out of any money in the Treasury not otherwise appropriated, $75,000,000 for each of fiscal years 2018 and 2019.

''(2) RESERVATION.—The Secretary shall reserve, for each of fiscal years 2018 and 2019, not more than 20 percent of the amount appropriated pursuant to paragraph (1) for administering the program under this section, including the conducting of national evaluations and the provision of technical assistance to the recipients of allotments.''.

(2) EFFECTIVE DATE.—The amendment made by this section takes effect on October 1, 2017.

(b) PERSONAL RESPONSIBILITY EDUCATION.—

(1) IN GENERAL.—Section 513 of the Social Security Act (42 U.S.C. 713) is amended—

(A) in subsection (a)(1)(A), by striking ''2017'' and inserting ''2019''; and

(B) in subsection (a)(4)—

(i) in subparagraph (A), by striking ''2017'' each place it appears and inserting ''2019''; and

(ii) in subparagraph (B)—

(I) in the subparagraph heading, by striking ''3-YEAR GRANTS'' and inserting ''COMPETITIVE PREP GRANTS''; and

(II) in clause (i), by striking ''solicit applications to award 3-year grants in each of fiscal years 2012 through 2017'' and inserting ''continue through fiscal year 2019 grants awarded for any of fiscal years 2015 through 2017'';

(C) in subsection (c)(1), by inserting after ''youth with HIV/AIDS,'' the following: ''victims of human trafficking,''; and

(D) in subsection (f), by striking ''2017'' and inserting ''2019''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on October 1, 2017.

SEC. 106. DECREASING REDUCTION IN MEDICAID DSH ALLOTMENTS.

Section 1923(f)(7)(A) of the Social Security Act (42 U.S.C. 1396r–4(f)(7)(A)) is amended—

(1) in clause (i), in the matter preceding subclause (I), by striking ''2018'' and inserting ''2023''; and

(2) in clause (ii), by striking subclauses (I) through (VIII) and inserting the following:

''(I) $5,000,000,000 for fiscal year 2023;

''(II) $5,500,000,000 for fiscal year 2024; and

''(III) $6,000,000,000 for fiscal year 2025.''.

SEC. 107. INCREASE IN TERRITORIAL CAP FOR MEDICAID PAYMENTS.

Section 1108(g)(5) of the Social Security Act (42 U.S.C. 1308(g)(5)) is amended—

(1) in subparagraph (A)—

(A) by striking ''subparagraph (B)'' and inserting ''subparagraphs (B), (C), and (D)''; and

(B) by striking ''2019'' and inserting ''2022''; and

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

''(C) The amount of the increase otherwise provided under subparagraph (A) for—

''(i) Puerto Rico shall, after application of subparagraph (B), be further increased by $1,600,000,000 for each of fiscal years 2018 through 2022; and

''(ii) the Virgin Islands shall be further increased by $55,000,000 for each of fiscal years 2018 through 2022.

''(D) The amount of the increase otherwise provided under subparagraph (A) for Guam, the Northern Mariana Islands, and America Samoa, respectively, shall be further increased by such amounts that the total amount of increases under this subparagraph is equal to $150,000,000. In applying the previous sentence, the Secretary shall increase amounts for such territories in such a proportion as would be applied under subparagraph (A) if such territories were the only territories to which such subparagraph applied.''.

SEC. 108. PUERTO RICO AND UNITED STATES VIRGIN ISLAND DISASTER RELIEF MEDICAID.

(a) SIMPLIFIED ELIGIBILITY DETERMINATIONS AND REDETERMINATIONS.—

(1) IN GENERAL.—Notwithstanding any provision of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), a State shall, as a condition of participation in the Medicaid program under such title and without submitting an amendment to the State Medicaid plan—

(A) use streamlined procedures described in paragraph (2) in processing applications and determining and redetermining eligibility for medical assistance under the State Medicaid plan for DRM-eligible Maria Survivors during the DRM coverage period; and

(B) provide, in the case of such a Survivor, for medical assistance under the State Medicaid plan to such Survivor during such period based on the family income level eligibility requirements established under the State Medicaid plan or, if higher, under the State Medicaid plan of the State in which such Survivor resided as of September 17, 2017.

(2) STREAMLINED PROCEDURES.—The streamlined procedures described in this paragraph, with respect to a State and an applicant for medical assistance under the State Medicaid plan, are the following:

(A) COMMON APPLICATION FORM.—Use of a common 1-page application form developed by the Secretary of Health and Human Services, in consultation with the National Association of State Medicaid Directors. Such form shall—

(i) require an applicant to provide an expected address for the duration of the DRM coverage period and to agree to update that information if it changes during such period;

(ii) include notice regarding the penalties for making a fraudulent application;

(iii) require the applicant to assign to the State any rights of the applicant (or any other person who is a DRM-eligible Maria Survivor and on whose behalf the applicant has the legal authority to execute an assignment of such rights) under any group health plan or other third-party coverage for health care; and

(iv) require the applicant to list any health insurance coverage which the applicant was enrolled in immediately prior to submitting such application.

(B) SELF-ATTESTATION.—Self-attestation by the applicant for medical assistance under the State Medicaid plan that the applicant is a DRM-eligible Maria Survivor, including with respect to citizenship, identity, immigration status, and income requirements.

(C) NO DOCUMENTATION.—No requirement for documentation evidencing the basis on which the applicant qualifies to be a DRM-eligible Maria Survivor.

(D) ISSUANCE OF ELIGIBILITY CARD.—Issuance of a DRM assistance eligibility card to an applicant who completes such application, including the self-attestation required under subparagraph (B). Such card shall be valid as long as the DRM coverage period is in effect and shall be accompanied by notice of the termination date for the DRM coverage period and, if applicable, notice that such termination date may be extended. If the President extends the DRM coverage period, the State shall notify DRM-eligible Maria Survivors enrolled in the State Medicaid plan of the new termination date for the DRM coverage period.

(E) DEEMED ELIGIBILITY.—If an applicant completes the application and presents it to a provider or facility participating in the State Medicaid plan that is qualified to make presumptive eligibility determinations under such plan (which at a minimum shall consist of facilities identified in section 1902(a)(55) of the Social Security Act (42 U.S.C. 1396a(a)(55)) and it appears to the provider that the applicant is a DRM-eligible Maria Survivor based on the information in the application, the applicant will be deemed to be a DRM-eligible Maria Survivor eligible for medical assistance under the State Medicaid plan.

(F) CONTINUOUS ELIGIBILITY.—Continuous eligibility, without the need for any redetermination of eligibility, for the duration of the DRM coverage period.

(b) NO CONTINUATION OF DRM ASSISTANCE.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), no DRM assistance shall be provided after the end of the DRM coverage period.

(2) PRESUMPTIVE ELIGIBILITY.—In the case of any DRM-eligible Maria Survivor who is receiving DRM assistance from a State in accordance with this section and who, as of the end of the DRM coverage period, has an application pending for medical assistance under the State Medicaid plan for periods beginning after the end of such period, the State shall provide such Survivor with a period of presumptive eligibility for medical assistance under the State Medicaid plan (not to exceed 60 days) until a determination with respect to the Survivor's application has been made.

(3) PREGNANT WOMEN.—In the case of a DRM-eligible Maria Survivor who is receiving DRM assistance from a State in accordance with this section and whose pregnancy ended during the 60-day period prior to the end of the DRM coverage period, or who is pregnant as of the end of such period, such Survivor shall continue to be eligible for DRM assistance after the end of the DRM coverage period, including (but not limited

to) all pregnancy-related and postpartum medical assistance available under the State Medicaid plan, through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

(c) TREATMENT OF MARIA SURVIVORS PROVIDED ASSISTANCE PRIOR TO DATE OF ENACTMENT.—Any Maria Survivor who is provided medical assistance under a State Medicaid plan in accordance with guidance from the Secretary during the period that begins on September 17, 2017, and ends on the date of enactment of this Act shall be treated as a DRM-eligible Maria Survivor, without the need to file an additional application, for purposes of eligibility for medical assistance under this section.

(d) SCOPE OF COVERAGE.—

(1) IN GENERAL.—A State providing medical assistance under a State Medicaid plan to a DRM-eligible Maria Survivor pursuant to this section shall provide medical assistance that is either—

(A) equal in amount and scope to the medical assistance that would otherwise be made available to such Survivor if the Survivor were a State resident enrolled in the State Medicaid plan; or

(B) if greater in amount and scope, equal in amount and scope to the medical assistance that would have been made available to such Survivor under the State Medicaid plan of the State in which such Survivor resided as of September 17, 2017.

Coverage for such medical assistance for DRM-eligible Maria Survivors shall be retroactive to items and services furnished on or after September 17, 2017 (or in the case of applications for DRM assistance submitted after January 1, 2018, the first day of the 5th month preceding the date on which such application is submitted).

(2) CHILDREN BORN TO PREGNANT WOMEN.—In the case of a child born to a DRM-eligible Maria Survivor who is provided DRM assistance during the DRM coverage period, such child shall be treated as having been born to a pregnant woman eligible for medical assistance under the State Medicaid plan and shall be eligible for medical assistance under such plan in accordance with section 1902(e)(4) of the Social Security Act (42 U.S.C. 1396a(e)(4)). The Federal medical assistance percentage applicable to the State Medicaid plan shall apply to medical assistance provided to a child under such plan in accordance with the preceding sentence and Federal payments for such assistance shall not be considered to be payments under this section.

(e) 100 PERCENT FEDERAL MATCHING PAYMENTS.—

(1) IN GENERAL.—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), subject to paragraph (2), the Federal medical assistance percentage or the Federal matching rate otherwise applied under section 1903(a) of such Act (42 U.S.C. 1396b(a)) shall be 100 percent for—

(A) providing DRM assistance to DRM-eligible Maria Survivors during the DRM coverage period in accordance with this section;

(B) costs directly attributable to administrative activities related to the provision of such DRM assistance; and

(C) DRM assistance provided in accordance with paragraph (2) or (3) of subsection (b) after the end of the DRM coverage period.

(2) LIMITATION.—

(A) TERRITORIES.—Payments provided to a State that is a territory (as defined in section 1108(c)(1) of the Social Security Act (42 U.S.C. 1308(c)(1))) in accordance with this subsection shall be subject to subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308).

(B) OTHER STATES.—

(i) IN GENERAL.—In the case of States not described in subparagraph (A), the difference between—

(I) the total amount of payments made to such States in accordance with this subsection, by reason of the Federal medical assistance percentage or the Federal matching rate applied under paragraph (1); and

(II) the total amount of payments that would otherwise be made to such States if the Federal medical assistance percentage and the Federal matching rate under section 1905(b) of the Social Security Act and 1903(a) of such Act were applied;

may not exceed the amount appropriated under clause (ii).

(ii) APPROPRIATIONS.—There are appropriated, out of any amounts in the Treasury not otherwise appropriated, $1,000,000,000 for the DRM coverage period for purposes of making payments in accordance with this subsection to States not described in subparagraph (A).

(3) EXEMPTION FROM ERROR RATE PENALTIES.—All payments attributable to providing DRM assistance in accordance with this section shall be disregarded for purposes of section 1903(u) of the Social Security Act (42 U.S.C. 1396b(u)).

(f) VERIFICATION OF STATUS AS A MARIA SURVIVOR.—

(1) IN GENERAL.—A State shall make a good faith effort to verify the status of an individual who is enrolled in the State Medicaid plan as a DRM-eligible Maria Survivor under the provisions of this section. Such effort shall not delay the determination of the eligibility of the Survivor for DRM assistance under this section.

(2) EVIDENCE OF VERIFICATION.—A State may satisfy the verification requirement under paragraph (1) with respect to an individual by showing that the State obtained information from the Social Security Administration, the Internal Revenue Service, or the State Medicaid Agency for the State from which the individual is from (if the individual was not a resident of such State on any day during the week preceding September 17, 2017).

(g) PROVIDER PAYMENT RATES.—In the case of any DRM assistance provided in accordance with this section to a DRM-eligible Maria Survivor that is covered under the State Medicaid plan (as applied without regard to this section) the State shall pay a provider of such assistance the same payment rate as the State would otherwise pay for the assistance if the assistance were provided under the State Medicaid plan (or, if no such payment rate applies under the State Medicaid plan, the usual and customary prevailing rate for the item or service for the community in which it is provided).

(h) APPLICATION TO INDIVIDUALS ELIGIBLE FOR MEDICAL ASSISTANCE.—Nothing in this section shall be construed as affecting any rights accorded to an individual who is a recipient of medical assistance under a State Medicaid plan who is determined to be a DRM-eligible Maria Survivor but the provision of DRM assistance to such individual shall be limited to the provision of such assistance in accordance with this section.

(i) DEFINITIONS.—In this section:

(1) DRM ASSISTANCE.—The term ''DRM assistance'' means medical assistance under a State Medicaid plan for a DRM-eligible Maria Survivor during the DRM coverage period.

(2) DRM COVERAGE PERIOD.—

(A) IN GENERAL.—The term ''DRM coverage period'' means the period beginning on September 17, 2017, and, subject to subparagraph (B), ending on the date that is 24 months after the date of enactment of this Act.

(B) SECRETARY AUTHORITY TO EXTEND DRM COVERAGE PERIOD.—The Secretary may extend the DRM coverage period for an additional 12 months. Any reference to the term ''DRM coverage period'' in this section shall include any extension under this subparagraph.

(3) DRM-ELIGIBLE MARIA SURVIVOR DEFINED.—

(A) IN GENERAL.—The term ''DRM-eligible Maria Survivor'' means a Maria Survivor whose family income does not exceed the income eligibility standard which would apply to the Survivor under the State Medicaid plan of the State in which the Survivor applies for medical assistance.

(B) NO RESOURCES, RESIDENCY, OR CATEGORICAL ELIGIBILITY REQUIREMENTS.—Eligibility under subparagraph (A) shall be determined without application of any resources test, State residency, or categorical eligibility requirements.

(C) DEFINITION OF CHILD.—For purposes of subparagraph (A), a DRM-eligible Maria Survivor shall be determined to be a ''child'' in accordance with the definition of ''child'' under the State Medicaid plan.

(4) MARIA SURVIVOR.—

(A) IN GENERAL.—The term ''Maria Survivor'' means an individual who, on any day during the week preceding September 17, 2017, had a primary residence in Puerto Rico or the Virgin Islands.

(B) TREATMENT OF CURRENT MEDICAID BENEFICIARIES.—Nothing in this section shall be construed as preventing an individual who is otherwise entitled to medical assistance under a State Medicaid plan from being treated as a Maria Survivor under this section.

(C) TREATMENT OF HOMELESS PERSONS.—For purposes of this section, in the case of an individual who was homeless on any day during the week described in subparagraph (A), the individual's ''residence'' shall be deemed to be the place of residence as otherwise determined for such an individual under title XIX of the Social Security Act (42 U.S.C 1396 et seq.).

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(6) STATE.—The term ''State'' has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C 1396 et seq.).

(7) STATE MEDICAID PLAN.—The term ''State Medicaid plan'' means a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan).

SEC. 109. DELAY OF BIPARTISAN BUDGET ACT OF 2013 THIRD PARTY LIABILITY PROVISIONS.

(a) IN GENERAL.—Section 202(c) of the Bipartisan Budget Act of 2013 (Public Law 113–67; 127 Stat. 1177; 42 U.S.C. 1396a note), as amended by section 211 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93; 128 Stat. 1047; 42 U.S.C. 1396a note) and section 220 of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10), is amended by striking ''2017'' and inserting ''2019''.

(b) EFFECTIVE DATE; TREATMENT.—The amendment made by subparagraph (A) shall take effect on September 30, 2017, and shall apply with respect to claims pending, generated, or filed after such date.

TITLE II—CHIP

SEC. 201. FIVE-YEAR FUNDING EXTENSION OF THE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) APPROPRIATION; TOTAL ALLOTMENT.—Section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) is amended—

(1) in paragraph (19), by striking ''and'';

(2) in paragraph (20), by striking the period at the end and inserting a semicolon; and

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

''(21) for fiscal year 2018, $21,500,000,000;
''(22) for fiscal year 2019, $22,600,000,000;
''(23) for fiscal year 2020, $23,700,000,000;
''(24) for fiscal year 2021, $24,800,000,000; and
''(25) for fiscal year 2022, for purposes of making 2 semi-annual allotments—
''(A) $2,850,000,000 for the period beginning on October 1, 2021, and ending on March 31, 2022; and
''(B) $2,850,000,000 for the period beginning on April 1, 2022, and ending on September 30, 2022.''.

(b) ALLOTMENTS.—
(1) IN GENERAL.—Section 2104(m) of the Social Security Act (42 U.S.C. 1397dd(m)) is amended—
(A) in paragraph (2)—
(i) in the heading, by striking ''THROUGH 2016'' and inserting ''THROUGH 2022''; and
(ii) in subparagraph (B)—
(I) in the matter preceding clause (i), by striking ''(19)'' and inserting ''(24)'';
(II) in clause (ii), in the matter preceding subclause (I), by inserting ''(other than fiscal year 2022)'' after ''even-numbered fiscal year''; and
(III) in clause (ii)(I), by inserting ''(or, in the case of fiscal year 2018, under paragraph (4))'' after ''clause (i)'';
(B) in paragraph (5)—
(i) by striking ''or (4)'' and inserting ''(4), or (10)''; and
(ii) by striking ''or 2017'' and inserting '', 2017, or 2022'';
(C) in paragraph (7)—
(i) in subparagraph (A), by striking ''2017'' and inserting ''2022'';
(ii) in subparagraph (B), in the matter preceding clause (i), by inserting ''(or, in the case of fiscal year 2018, by not later than the date that is 60 days after the date of the enactment of the CHAMPION KIDS Act of 2017)'' after ''before the August 31 preceding the beginning of the fiscal year''; and
(iii) in the matter following subparagraph (B), by striking ''or fiscal year 2016'' and inserting ''fiscal year 2016, fiscal year 2018, fiscal year 2020, or fiscal year 2022'';
(D) in paragraph (9)—
(i) in the heading, by striking ''FISCAL YEARS 2015 AND 2017'' and inserting ''CERTAIN FISCAL YEARS'';
(ii) by striking ''or (4)'' and inserting '', (4), or (10)''; and
(iii) by striking ''or fiscal year 2017'' and inserting '', 2017, or 2022''; and
(E) by adding at the end the following new paragraph:
''(10) FOR FISCAL YEAR 2022.—
''(A) FIRST HALF.—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (A) of paragraph (25) of subsection (a) for the semi-annual period described in such subparagraph, increased by the amount of the appropriation for such period under section 201(b)(3) of the CHAMPION KIDS Act of 2017, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the first half ratio (described in subparagraph (D)) of the amount described in subparagraph (C).
''(B) SECOND HALF.—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (B) of paragraph (25) of subsection (a) for the semi-annual period described in such subparagraph, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the amount made available under such subparagraph, multiplied by the ratio of—
''(i) the amount of the allotment to such State under subparagraph (A); to
''(ii) the total of the amount of all of the allotments made available under such subparagraph.
''(C) FULL YEAR AMOUNT BASED ON GROWTH FACTOR UPDATED AMOUNT.—The amount described in this subparagraph for a State is equal to the sum of—
''(i) the amount of the State allotment for fiscal year 2021 determined under paragraph (2)(B)(i); and
''(ii) the amount of any payments made to the State under subsection (n) for fiscal year 2021,
multiplied by the allotment increase factor under paragraph (6) for fiscal year 2022.
''(D) FIRST HALF RATIO.—The first half ratio described in this subparagraph is the ratio of—
''(i) the sum of—
''(I) the amount made available under subsection (a)(25)(A); and
''(II) the amount of the appropriation for such period under section 201(b)(3) of the CHAMPION KIDS Act of 2017; to
''(ii) the sum of—
''(I) the amount described in clause (i); and
''(II) the amount made available under subsection (a)(25)(B).''.
(2) TECHNICAL AMENDMENT.—Section 2104(m)(2)(A) of such Act (42 U.S.C. 1397dd(m)(2)(A)) is amended by striking ''the allotment increase factor under paragraph (5)'' each place it appears and inserting ''the allotment increase factor under paragraph (6)''.
(3) ONE-TIME APPROPRIATION FOR FISCAL YEAR 2022.—There is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated, $20,200,000,000 to accompany the allotment made for the period beginning on October 1, 2021, and ending on March 31, 2022, under paragraph (25)(A) of section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) (as added by subsection (a)(3)), to remain available until expended. Such amount shall be used to provide allotments to States under paragraph (10) of section 2104(m) of such Act (as added by subsection (b)(1)(E)) for the first 6 months of fiscal year 2022 in the same manner as allotments are provided under subsection (a)(25)(A) of such section 2104 and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(25)(A).
(c) EXTENSION OF THE CHILD ENROLLMENT CONTINGENCY FUND.—Section 2104(n) of the Social Security Act (42 U.S.C. 1397dd(n)) is amended—
(1) in paragraph (2)—
(A) in subparagraph (A)(ii)—
(i) by striking ''2010, 2011, 2012, 2013, 2014, and 2016'' and inserting ''2010 through 2014, 2016, and 2018 through 2021''; and
(ii) by striking ''fiscal year 2015 and fiscal year 2017'' and inserting ''fiscal years 2015, 2017, and 2022''; and
(B) in subparagraph (B)—
(i) by striking ''2010, 2011, 2012, 2013, 2014, and 2016'' and inserting ''2010 through 2014, 2016, and 2018 through 2021''; and
(ii) by striking ''fiscal year 2015 and fiscal year 2017'' and inserting ''fiscal year 2015, 2017, and 2022''; and
(2) in paragraph (3)(A), in the matter preceding clause (i), by striking ''or a semi-annual allotment period for fiscal year 2015 or 2017'' and inserting ''or in any of fiscal years 2018 through 2021 (or a semi-annual allotment period for fiscal year 2015, 2017, or 2022)''.
(d) EXTENSION OF QUALIFYING STATES OPTION.—Section 2105(g)(4) of the Social Security Act (42 U.S.C. 1397ee(g)(4)) is amended—
(1) in the heading, by striking ''THROUGH 2017'' and inserting ''THROUGH 2022''; and
(2) in subparagraph (A), by striking ''2017'' and inserting ''2022''.
(e) EXTENSION OF EXPRESS LANE ELIGIBILITY OPTION.—Section 1902(e)(13)(I) of the Social Security Act (42 U.S.C. 1396a(e)(13)(I)) is amended by striking ''2017'' and inserting ''2022''.
(f) ASSURANCE OF AFFORDABILITY STANDARD FOR CHILDREN AND FAMILIES.—
(1) IN GENERAL.—Section 2105(d)(3) of the Social Security Act (42 U.S.C. 1397ee(d)(3)) is amended—
(A) in the paragraph heading, by striking ''UNTIL OCTOBER 1, 2019'' and inserting ''THROUGH SEPTEMBER 30, 2022''; and
(B) in subparagraph (A), in the matter preceding clause (i)—
(i) by striking ''2019'' and inserting ''2022''; and
(ii) by striking ''The preceding sentence shall not be construed as preventing a State during such period'' and inserting ''During the period that begins on October 1, 2019, and ends on September 30, 2022, the preceding sentence shall only apply with respect to children in families whose income does not exceed 300 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved. The preceding sentences shall not be construed as preventing a State during any such periods''.
(2) CONFORMING AMENDMENTS.—Section 1902(gg)(2) of the Social Security Act (42 U.S.C. 1396a(gg)(2)) is amended—
(A) in the paragraph heading, by striking ''UNTIL OCTOBER 1, 2019'' and inserting ''THROUGH SEPTEMBER 30, 2022''; and
(B) by striking ''September 30, 2019,'' and inserting ''September 30, 2022 (but during the period that begins on October 1, 2019, and ends on September 30, 2022, only with respect to children in families whose income does not exceed 300 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved)''.

SEC. 202. EXTENSION OF CERTAIN PROGRAMS AND DEMONSTRATION PROJECTS.

(a) CHILDHOOD OBESITY DEMONSTRATION PROJECT.—Section 1139A(e)(8) of the Social Security Act (42 U.S.C. 1320b–9a(e)(8)) is amended—
(1) by striking ''and $10,000,000'' and inserting '', $10,000,000''; and
(2) by inserting after ''2017'' the following: '', and $25,000,000 for the period of fiscal years 2018 through 2022''.
(b) PEDIATRIC QUALITY MEASURES PROGRAM.—Section 1139A(i) of the Social Security Act (42 U.S.C. 1320b–9a(i)) is amended—
(1) by striking ''Out of any'' and inserting the following:
''(1) IN GENERAL.—Out of any'';
(2) by striking ''there is appropriated for each'' and inserting ''there is appropriated—
''(A) for each'';
(3) by striking '', and there is appropriated for the period'' and inserting '';
''(B) for the period'';
(4) by striking ''. Funds appropriated under this subsection shall remain available until expended'' and inserting ''; and''; and
(5) by adding at the end the following:
''(C) for the period of fiscal years 2018 through 2022, $75,000,000 for the purpose of carrying out this section (other than subsections (e), (f), and (g)).
''(2) AVAILABILITY.—Funds appropriated under this subsection shall remain available until expended.''.

SEC. 203. EXTENSION OF OUTREACH AND ENROLLMENT PROGRAM.

(a) EXTENSION AND REAUTHORIZATION.—Section 2113 of the Social Security Act (42 U.S.C. 1397mm) is amended—
(1) in subsection (a)(1), by striking ''2017'' and inserting ''2022''; and
(2) in subsection (g)—
(A) by striking ''and $40,000,000'' and inserting '', $40,000,000''; and

(B) by inserting after ''2017'' the following: '', and $100,000,000 for the period of fiscal years 2018 through 2022''.

(b) MAKING ORGANIZATIONS THAT USE PARENT MENTORS ELIGIBLE TO RECEIVE GRANTS.—Section 2113(f) of the Social Security Act (42 U.S.C. 1397mm(f)) is amended—

(1) in paragraph (1)(E), by striking ''or community-based doula programs'' and inserting '', community-based doula programs, or parent mentors''; and

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

''(5) PARENT MENTOR.—The term 'parent mentor' means an individual who—

''(A) is a parent or guardian of at least one child who is an eligible child under this title or title XIX; and

''(B) is trained to assist families with children who have no health insurance coverage with respect to improving the social determinants of the health of such children, including by providing—

''(i) education about health insurance coverage, including, with respect to obtaining such coverage, eligibility criteria and application and renewal processes;

''(ii) assistance with completing and submitting applications for health insurance coverage and renewal;

''(iii) a liaison between families and representatives of State plans under title XIX or State child health plans under this title;

''(iv) guidance on identifying medical and dental homes and community pharmacies for children; and

''(v) assistance and referrals to successfully address social determinants of children's health, including poverty, food insufficiency, housing, and environmental hazards.''.

(c) EXCLUSION FROM MODIFIED ADJUSTED GROSS INCOME.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(17), by striking ''(e)(14), (e)(14)'' and inserting ''(e)(14), (e)(15)'';

(2) in subsection (e), in the first paragraph (14), relating to income determined using modified adjusted gross income, by adding at the end the following new subparagraph:

''(J) EXCLUSION OF PARENT MENTOR COMPENSATION FROM INCOME DETERMINATION.—Any nominal amount received by an individual as compensation, including a stipend, for participation as a parent mentor (as defined in paragraph (5) of section 2113(f)) in an activity or program funded through a grant under such section 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.''; and

(3) in subsection (e), by striking ''(14) EXCLUSION'' and inserting ''(15) EXCLUSION''.

SEC. 204. EXTENSION OF ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR CHIP.

Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended in the second sentence by inserting ''and during the period that begins on October 1, 2019, and ends on September 30, 2020, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 11.5 percentage points'' after ''23 percentage points,''.

TITLE III—OFFSET

SEC. 301. IMPLEMENTATION OF OFFICE OF INSPECTOR GENERAL RECOMMENDATION TO DELAY CERTAIN MEDICARE PLAN PREPAYMENTS.

(a) MEDICARE ADVANTAGE PAYMENTS.—Section 1853(a)(1) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i)—

(A) by striking ''subsections (e), (g), (i), and (l)'' and inserting ''subparagraph (J), subsections (e), (g), (i), and (l),''; and

(B) by inserting ''(or, for months beginning with January 2019, on the date specified in subparagraph (J))'' after ''in advance''; and

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

''(J) TIMING OF PAYMENTS.—

''(i) IN GENERAL.—With respect to monthly payments under this section for months in a year (beginning with 2019), the date specified in this subparagraph with respect to a payment for a month is the first business day occurring on or after the applicable date defined in clause (ii).

''(ii) APPLICABLE DATE.—For purposes of clause (i), with respect to a year (beginning with 2019), the term 'applicable date' means, with respect to a payment for—

''(I) January of such year, January 2nd;

''(II) February of such year, February 5th;

''(III) March of such year, March 10th;

''(IV) April of such year, April 15th;

''(V) May of such year, May 20th;

''(VI) June of such year, June 25th;

''(VII) July and each succeeding month (other than December) of such year, the first day of the next month; and

''(VIII) December of such year, December 24th.''.

(b) CONFORMING AMENDMENT TO PART D.—Section 1860D–15(d)(1) of the Social Security Act (42 U.S.C. 1395w–115(d)(1)) is amended by inserting ''and shall be made consistent with the timing of monthly payments to MA organizations under section 1853(a)(1)(J)'' after ''as the Secretary determines''.

Mr. CLYBURN (during the reading). Mr. Speaker, I ask unanimous consent to dispense with the reading.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from South Carolina?

There was no objection.

Mr. WALDEN. Mr. Speaker, I reserve a point of order against the motion to recommit.

The SPEAKER pro tempore. The gentleman's point of order is reserved.

Pursuant to the rule, the gentleman from South Carolina is recognized for 5 minutes in support of his motion.

Mr. CLYBURN. Mr. Speaker, the Republicans have reserved a point of order against this motion.

Let me be clear about what this means. The Republican leadership does not want a vote on providing proper CHIP funds to our United States territories, including Puerto Rico and the Virgin Islands.

There may be a point of order against this provision, but it is the same point of order that applies to the Republicans' bill.

Do you know what that means?

They waive the point of order for their bill, but they will not waive the point of order for this bill.

I won't take up too much time, Mr. Speaker. I just want the body to know that the Republican leadership is, once again, rigging the game in favor of the majority.

This isn't about hurting me and the Democratic Members of this body, no. This hurts the people who are already struggling in Puerto Rico and the Virgin Islands.

□ 1030

To my friends on the other side of the aisle, you may hide behind procedural tactics, but the fact remains that doing so denies our United States citizens living in the territories the proper funding that the Governor has requested to recover.

Mr. Speaker, this is the final amendment to the bill which will not kill the bill nor send it back to committee. If adopted, the bill will immediately proceed to final passage as amended.

It has been 34 days, Mr. Speaker, since Republicans allowed the Children's Health Insurance Program and Community Health Centers to expire. These proven programs insure 9 million children and serve 27 million people.

The bill before us is the latest in a long line of cynical attempts by President Trump and Republican Leaders to sabotage and undermine the Affordable Care Act. We ought not be funding efforts to treat infectious diseases like the flu and measles by taking away the funds needed to prevent those illnesses from occurring in the first place.

Mr. Speaker, this bill turns on its head that adage, ''an ounce of prevention is worth a pound of cure.'' Instead of joining President Trump's campaign to sabotage the ACA, the Members of this body, Republicans and Democrats, should join to reauthorize CHIP and CHCs for 5 years, fully paid for without robbing Peter to pay Paul.

Mr. Speaker, I yield back the balance of my time.

Mr. WALDEN. Mr. Speaker, I withdraw my reservation of a point of order.

The SPEAKER pro tempore. The reservation of a point of order is withdrawn.

Mr. WALDEN. Mr. Speaker, I claim the time in opposition to the motion to recommit.

The SPEAKER pro tempore. The gentleman from Oregon is recognized for 5 minutes.

Mr. WALDEN. Mr. Speaker, today, Members of this House can deliver peace of mind to parents of over 8 million low-income children who depend on the Children's Health Insurance Program. The House can extend funding for important public health programs, including resources for the critical work community health centers do in our communities and in my district and yours. This bill will help deliver much-needed healthcare resources to our friends and fellow citizens in the Virgin Islands and in Puerto Rico.

Yet we have heard complaints about how this package is paid for. Well, let us be clear how this bill funds healthcare for kids and important public health priorities like community health centers.

In paying for this package, we have taken a fiscally responsible and reasonable approach. Our bill funds kids' healthcare by allowing States to disenroll lottery winners—these are winners making $80,000 or above—from the low-income Medicaid program. We ensure high-dollar lottery winners are removed from the Medicaid program so that those resources can go to Medicaid-eligible, low-income people in our districts.

Our bill directs funding from the Prevention and Public Health Fund to finance important prevention and public

health needs, like funding the National Health Service Corps, Teaching Health Center Graduate Medical Education, Family-to-Family Health Information Centers, and community health centers. If these are not important programs for prevention, wellness, and public health, I don't know what are.

Our bill before us today, which I predict will have bipartisan support, directs funds from the Prevention Fund for important public health priorities that have long had bipartisan support. We are using a bipartisan fund to pay for bipartisan healthcare support for health and wellness, which was its intent from the beginning.

Most recently, nearly every House Republican and Democrat supported this idea just a year ago. Just a year ago, when we passed the 21st Century Cures Act, we said: Here is a health and wellness fund and a Prevention Fund that makes sense for cures, make sense for, we believe today, our community health centers, and for Children's Health Insurance.

Our bill also asks the wealthiest among us, the 1 percent of beneficiaries, those making $40,000 a month, over half-a-million dollars a year—that is an individual—to pay a little more to help fund health insurance for low-income children. I think they are willing to do that, and I think we should be as well.

On multiple budgets, President Obama said this is a reasonable way to pay for other priorities. That was bipartisan. It is bipartisan today.

These reasonable pay-fors have been opposed by some in the Democratic leadership. Some House Democrats want to use children's healthcare and funding for community health centers as a bargaining chip for a bigger end-of-the-year goulash, yet kids and our frontline providers can't wait any longer.

In just a few weeks, States like Minnesota run out of funding for the Children's Health Insurance Program. At the request of my colleagues on the other side of the aisle, we have agreed to postpone it time and again, but time has run out. The negotiations did not end as we all hoped they would.

But we can't wait any longer. It is time for this House to deliver peace of mind to the families that rely on these critical programs. It is time to vote ''yes.''

Mr. Speaker, I urge my colleagues to vote ''no'' on the motion to recommit and to approve the underlying bill, and I yield back the balance of my time.

Ms. BLUNT ROCHESTER. Mr. Speaker, I thank my friend and mentor, the gentleman from South Carolina, for his kind words and for yielding.

Mr. Speaker, we deal with important issues every day in this House, but there are few issues as meaningful to so many lives as the Children's Health Insurance Program.

At this time the divisions in this House mimic those in our nation.

And on many issues, those divisions can be challenging to bridge.

One of my top priorities as a new Member of this body is to help bridge those divides, instead of widening them.

I hope that my colleagues—both Democrats and Republicans—will tell me if I fall short on that commitment.

One of the few things that does not divide us is the importance of children's healthcare and the CHIP program.

When it was signed into law 20 years ago, this landmark legislation meant so much to me.

First, as a mother of then 9-year-old, Alyssa, and 11-year-old, Alex I deeply understood the fear a parent could feel with a sick child and no insurance.

But also because at that time, I was the Deputy Secretary of Health & Social Services for Delaware.

And I had the honor of helping implement the law and seeing thousands of children who had never had healthcare get the coverage they deserved.

From the 600,000 children across the nation who were the program's first enrollees in 1998 to the nearly 9,000,000 children in 2016.

Kids across this country owe their yearly check-ups, their immunizations, and their doctor's office lollipops to this program.

And in Delaware we owe a big debt to the CHIP program, Medicaid, and the Affordable Care Act.

Today, 97 percent of Delaware's children obtain medical coverage because of these programs.

In 1997, the legislation passed in a Republican Congress with a Democratic President, highlighting how this truly was not a partisan issue.

That's why it's disappointing to me that we aren't moving forward on renewing the Children's Health Insurance Program with that same reasonable, bipartisan approach.

The bill before us today forces us to choose between healthcare for children and healthcare for other vulnerable populations.

Choosing between prevention and healthcare for kids is unacceptable—particularly in a nation as great as ours.

I have spoken to many of you over the past 10 months.

I know that the people I have met in both political parties know—in their hearts—that we should not play games with the healthcare of our children.

I know that it may seem hard to oppose one's party leadership. But today I ask you to consider whether this is one of those rare times . . . those rare subjects . . .

Where we can come together to stand up for the those in need . . .

And to stand up for a clean reauthorization of the Children's Health Insurance Program.

That's what our motion to recommit does.

Let's step back and consider whether we can use our common desire to deliver healthcare to our children, as a moment to surprise the public . . .

To set a new tone for how we deal with one another . . . and how we address issues on which both of our parties fundamentally agree.

Please join with me on this vote to put our children first—they're watching.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. CLYBURN. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 and clause 9 of rule XX, this 15-minute vote on the motion to recommit will be followed by 5-minute votes on the question of passage of H.R. 3922, if ordered, and approval of the Journal, if ordered.

The vote was taken by electronic device, and there were—yeas 187, nays 231, not voting 14, as follows:

[Roll No. 605]

YEAS—187

Adams	Fudge	Neal
Aguilar	Gabbard	Nolan
Barragán	Gallego	Norcross
Bass	Garamendi	O'Halleran
Beatty	Gomez	O'Rourke
Bera	Gonzalez (TX)	Pallone
Beyer	Gottheimer	Panetta
Blumenauer	Green, Al	Pascrell
Blunt Rochester	Green, Gene	Payne
Bonamici	Grijalva	Pelosi
Boyle, Brendan F.	Hanabusa	Perlmutter
	Hastings	Peterson
Brady (PA)	Heck	Pingree
Brown (MD)	Higgins (NY)	Polis
Brownley (CA)	Himes	Price (NC)
Bustos	Hoyer	Quigley
Butterfield	Huffman	Raskin
Capuano	Jayapal	Rice (NY)
Carbajal	Jeffries	Richmond
Cárdenas	Johnson (GA)	Rosen
Carson (IN)	Kaptur	Roybal-Allard
Cartwright	Keating	Ruiz
Castor (FL)	Kelly (IL)	Ruppersberger
Castro (TX)	Kennedy	Rush
Chu, Judy	Khanna	Ryan (OH)
Cicilline	Kihuen	Sánchez
Clark (MA)	Kildee	Sarbanes
Clarke (NY)	Kilmer	Schakowsky
Clay	Kind	Schiff
Cleaver	Krishnamoorthi	Schneider
Clyburn	Kuster (NH)	Schrader
Cohen	Langevin	Scott (VA)
Connolly	Larsen (WA)	Scott, David
Conyers	Larson (CT)	Serrano
Cooper	Lawrence	Sewell (AL)
Correa	Lawson (FL)	Shea-Porter
Costa	Lee	Sherman
Courtney	Levin	Sinema
Crist	Lewis (GA)	Sires
Crowley	Lieu, Ted	Slaughter
Cuellar	Lipinski	Smith (WA)
Cummings	Loebsack	Soto
Davis (CA)	Lofgren	Speier
Davis, Danny	Lowenthal	Suozzi
DeFazio	Lowey	Swalwell (CA)
DeGette	Lujan Grisham, M.	Takano
Delaney		Thompson (CA)
DeLauro	Luján, Ben Ray	Thompson (MS)
DelBene	Lynch	Titus
Demings	Maloney, Carolyn B.	Tonko
DeSaulnier		Torres
Deutch	Maloney, Sean	Tsongas
Dingell	Matsui	Vargas
Doggett	McCollum	Veasey
Doyle, Michael F.	McEachin	Vela
	McGovern	Velázquez
Ellison	McNerney	Visclosky
Engel	Meeks	Walz
Eshoo	Meng	Wasserman Schultz
Espaillat	Moore	
Esty (CT)	Moulton	Waters, Maxine
Evans	Murphy (FL)	Watson Coleman
Foster	Nadler	Welch
Frankel (FL)	Napolitano	Yarmuth

NAYS—231

Abraham	Barr	Bost
Allen	Barton	Brady (TX)
Amash	Bergman	Brat
Amodei	Biggs	Brooks (IN)
Arrington	Bilirakis	Buchanan
Babin	Bishop (MI)	Buck
Bacon	Bishop (UT)	Bucshon
Banks (IN)	Blackburn	Budd
Barletta	Blum	Burgess

Byrne
Calvert
Carter (GA)
Carter (TX)
Chabot
Cheney
Coffman
Cole
Collins (GA)
Collins (NY)
Comer
Comstock
Conaway
Cook
Costello (PA)
Cramer
Crawford
Culberson
Curbelo (FL)
Davidson
Davis, Rodney
Denham
Dent
DeSantis
DesJarlais
Diaz-Balart
Donovan
Duffy
Duncan (SC)
Duncan (TN)
Dunn
Emmer
Estes (KS)
Farenthold
Faso
Ferguson
Fitzpatrick
Fleischmann
Flores
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gaetz
Gallagher
Garrett
Gianforte
Gibbs
Gohmert
Goodlatte
Gosar
Gowdy
Granger
Graves (GA)
Graves (LA)
Graves (MO)
Griffith
Grothman
Guthrie
Handel
Harper
Harris
Hartzler
Hensarling
Herrera Beutler
Hice, Jody B.
Higgins (LA)
Hill
Holding
Hollingsworth
Hudson
Huizenga
Hultgren
Hunter
Hurd
Issa
Jenkins (KS)
Jenkins (WV)
Johnson (LA)
Johnson (OH)
Jones
Jordan
Joyce (OH)
Katko
Kelly (MS)
Kelly (PA)
King (IA)
King (NY)
Kinzinger
Knight
Kustoff (TN)
Labrador
LaHood
Lamborn
Lance
Latta
Lewis (MN)
LoBiondo
Long
Loudermilk
Love
Lucas
Luetkemeyer
MacArthur
Marchant
Marino
Marshall
Massie
Mast
McCarthy
McCaul
McClintock
McHenry
McKinley
McMorris Rodgers
McSally
Meadows
Meehan
Messer
Mitchell
Moolenaar
Mooney (WV)
Mullin
Newhouse
Noem
Norman
Nunes
Olson
Palazzo
Palmer
Paulsen
Pearce
Perry
Pittenger
Poe (TX)
Poliquin
Posey
Ratcliffe
Reed
Reichert
Renacci
Rice (SC)
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rohrabacher
Rokita
Rooney, Francis
Rooney, Thomas J.
Ros-Lehtinen
Roskam
Ross
Rothfus
Rouzer
Royce (CA)
Russell
Rutherford
Sanford
Scalise
Schweikert
Scott, Austin
Sensenbrenner
Sessions
Shimkus
Shuster
Simpson
Smith (MO)
Smith (NE)
Smith (NJ)
Smith (TX)
Smucker
Stefanik
Stewart
Stivers
Taylor
Tenney
Thompson (PA)
Thornberry
Tiberi
Tipton
Trott
Turner
Valadao
Wagner
Walberg
Walden
Walker
Walorski
Walters, Mimi
Weber (TX)
Webster (FL)
Wenstrup
Westerman
Williams
Wilson (SC)
Wittman
Womack
Woodall
Yoder
Yoho
Young (AK)
Young (IA)
Zeldin

NOT VOTING—14

Aderholt
Bishop (GA)
Black
Bridenstine
Brooks (AL)
Gutiérrez
Jackson Lee
Johnson, E. B.
Johnson, Sam
LaMalfa
Peters
Pocan
Upton
Wilson (FL)

□ 1058

Messrs. BARTON, PALAZZO, CALVERT, SMITH of Texas, COLLINS of New York, WITTMAN, Ms. GRANGER, Messrs. HOLDING, SCALISE, and Ms. HERRERA BEUTLER changed their vote from ''yea'' to ''nay.''

Ms. JAYAPAL, Messrs. TAKANO, LANGEVIN, and DAVID SCOTT of Georgia changed their vote from ''nay'' to ''yea.''

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. PALLONE. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 242, nays 174, not voting 16, as follows:

[Roll No. 606]

YEAS—242

Abraham
Allen
Amodei
Arrington
Babin
Bacon
Banks (IN)
Barletta
Barr
Barton
Bera
Bergman
Bilirakis
Bishop (MI)
Bishop (UT)
Blackburn
Blum
Bost
Brady (TX)
Brat
Brooks (IN)
Buchanan
Buck
Bucshon
Budd
Burgess
Byrne
Calvert
Carbajal
Carter (GA)
Carter (TX)
Chabot
Cheney
Coffman
Cole
Collins (GA)
Collins (NY)
Comer
Comstock
Conaway
Cook
Correa
Costa
Costello (PA)
Cramer
Crawford
Cuellar
Culberson
Curbelo (FL)
Davidson
Davis, Rodney
Denham
Dent
DeSantis
DesJarlais
Diaz-Balart
Donovan
Duffy
Duncan (SC)
Duncan (TN)
Dunn
Emmer
Estes (KS)
Farenthold
Faso
Ferguson
Fitzpatrick
Fleischmann
Flores
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gaetz
Gallagher
Garrett
Gianforte
Gibbs
Gohmert
Goodlatte
Gosar
Gowdy
Granger
Graves (GA)
Graves (LA)
Graves (MO)
Griffith
Grothman
Guthrie
Handel
Harper
Harris
Hartzler
Hensarling
Herrera Beutler
Hice, Jody B.
Higgins (LA)
Hill
Holding
Hollingsworth
Hudson
Huizenga
Hultgren
Hunter
Hurd
Issa
Jenkins (KS)
Jenkins (WV)
Johnson (LA)
Johnson (OH)
Jones
Jordan
Joyce (OH)
Katko
Kelly (MS)
Kelly (PA)
Kind
King (IA)
King (NY)
Kinzinger
Knight
Kustoff (TN)
Labrador
LaHood
Lamborn
Lance
Latta
Lewis (MN)
Lipinski
LoBiondo
Loebsack
Long
Loudermilk
Love
Lucas
Luetkemeyer
MacArthur
Marchant
Marino
Marshall
Mast
McCarthy
McCaul
McClintock
McHenry
McKinley
McMorris Rodgers
McSally
Meadows
Meehan
Messer
Mitchell
Moolenaar
Mooney (WV)
Mullin
Murphy (FL)
Newhouse
Noem
Norman
Nunes
O'Halleran
Olson
Palazzo
Palmer
Paulsen
Pearce
Perry
Peterson
Pittenger
Poe (TX)
Poliquin
Posey
Ratcliffe
Reed
Reichert
Renacci
Rice (SC)
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rohrabacher
Rokita
Rooney, Francis
Rooney, Thomas J.
Ros-Lehtinen
Rosen
Roskam
Ross
Rothfus
Rouzer
Royce (CA)
Russell
Rutherford
Sanford
Scalise
Schneider
Schrader
Schweikert
Scott, Austin
Sensenbrenner
Sessions
Shimkus
Shuster
Simpson
Sinema
Smith (MO)
Smith (NE)
Smith (NJ)
Smith (TX)
Smucker
Stefanik
Stewart
Stivers
Taylor
Tenney
Thompson (PA)
Thornberry
Tiberi
Tipton
Trott
Turner
Valadao
Wagner
Walberg
Walden
Walker
Walorski
Walters, Mimi
Weber (TX)
Webster (FL)
Wenstrup
Westerman
Wilson (SC)
Wittman
Womack
Woodall
Yoder
Yoho
Young (AK)
Young (IA)
Zeldin

NAYS—174

Adams
Aguilar
Amash
Barragán
Bass
Beatty
Beyer
Biggs
Blumenauer
Blunt Rochester
Bonamici
Boyle, Brendan F.
Brady (PA)
Brown (MD)
Brownley (CA)
Bustos
Butterfield
Capuano
Cárdenas
Carson (IN)
Cartwright
Castor (FL)
Castro (TX)
Chu, Judy
Cicilline
Clark (MA)
Clarke (NY)
Clay
Cleaver
Clyburn
Cohen
Connolly
Conyers
Cooper
Courtney
Crist
Crowley
Cummings
Davis (CA)
Davis, Danny
DeFazio
DeGette
Delaney
DeLauro
DelBene
Demings
DeSaulnier
Deutch
Dingell
Doggett
Doyle, Michael F.
Ellison
Engel
Eshoo
Espaillat
Esty (CT)
Evans
Foster
Frankel (FL)
Fudge
Gabbard
Gallego
Garamendi
Gomez
Gonzalez (TX)
Gottheimer
Green, Al
Green, Gene
Grijalva
Hanabusa
Hastings
Heck
Higgins (NY)
Himes
Hoyer
Huffman
Jayapal
Jeffries
Johnson (GA)
Kaptur
Keating
Kelly (IL)
Kennedy
Khanna
Kihuen
Kildee
Kilmer
Krishnamoorthi
Kuster (NH)
Langevin
Larsen (WA)
Larson (CT)
Lawrence
Lawson (FL)
Lee
Levin
Lewis (GA)
Lieu, Ted
Lofgren
Lowenthal
Lowey
Lujan Grisham, M.
Luján, Ben Ray
Lynch
Maloney, Carolyn B.
Maloney, Sean
Massie
Matsui
McCollum
McEachin
McGovern
McNerney
Meeks
Meng
Moore
Moulton
Nadler
Napolitano
Neal
Nolan
Norcross
O'Rourke
Pallone
Panetta
Pascrell
Payne
Pelosi
Perlmutter
Pingree
Polis
Price (NC)
Quigley
Raskin
Rice (NY)
Richmond
Roybal-Allard
Ruiz
Ruppersberger
Rush
Ryan (OH)
Sánchez
Sarbanes
Schakowsky
Schiff
Scott (VA)
Scott, David
Serrano
Sewell (AL)
Shea-Porter
Sherman
Sires
Slaughter
Smith (WA)
Soto
Suozzi
Swalwell (CA)
Takano
Thompson (CA)
Thompson (MS)
Titus
Tonko
Torres
Tsongas
Vargas
Veasey
Vela
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters, Maxine
Watson Coleman
Welch
Yarmuth

NOT VOTING—16

Aderholt
Bishop (GA)
Black
Bridenstine
Brooks (AL)
Gutiérrez
Jackson Lee
Johnson, E. B.
Johnson, Sam
LaMalfa
Peters
Pocan
Speier
Upton
Williams
Wilson (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining.

□ 1106

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. PETERS. Mr. Speaker, my vote was not recorded on rollcall No. 606 on H.R. 3922—The Community Health and Medical Professionals Improve Our Nation Act due to my attendance at the Vatican's Health of People, Health of Planet and Our Responsibility: Climate Change, Air Pollution and Health. I intended to vote ''aye.''

Mr. LAMALFA. Mr. Speaker, on rollcall No. 606 on passage of H.R. 3922, I am not recorded due to a family concern. Had I been present, I would have voted ''yea.''

PERSONAL EXPLANATION

Ms. SPEIER. Mr. Speaker, due to an unavoidable conflict, I missed the following votes on November 1, 2, and 3. Had I been present, I would have voted "yea" on rollcall No. 597, "nay" on rollcall No. 604, "yea" on rollcall No. 605, and "nay" on rollcall No. 606.

PERSONAL EXPLANATION

Mrs. BLACK. Mr. Speaker, I was unavoidably detained. Had I been present, I would have voted "yea" on rollcall No. 604, and "yea" on rollcall No. 606.

THE JOURNAL

The SPEAKER pro tempore (Mr. BANKS of Indiana). The unfinished business is the question on agreeing to the Speaker's approval of the Journal, which the Chair will put de novo.

The question is on the Speaker's approval of the Journal.

Pursuant to clause 1, rule I, the Journal stands approved.

□ 1115

LEGISLATIVE PROGRAM

(Mr. HOYER asked and was given permission to address the House for 1 minute.)

Mr. HOYER. Mr. Speaker, I yield to the gentleman from California (Mr. MCCARTHY), the majority leader, for the purpose of inquiring about the schedule for the week to come.

(Mr. MCCARTHY asked and was given permission to revise and extend his remarks.)

Mr. MCCARTHY. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, on Monday, the House will meet at noon for morning hour and 2 p.m. for legislative business. Votes will be postponed until 6:30. On Tuesday and Wednesday, the House will meet at 10 a.m. for morning hour and noon for legislative business. On Thursday, the House will meet at 9:00 a.m. for legislative business. On Friday, no votes are expected in the House.

Mr. Speaker, the House will consider a number of suspensions next week, a complete list of which will be announced by close of business today.

In addition, the House will consider H.R. 3043, the Hydropower Policy Modernization Act, sponsored by Representative CATHY MCMORRIS RODGERS. This bill will continue our efforts to improve America's energy infrastructure by streamlining the FERC licensing process for hydropower projects.

The House will also consider two good jobs bills: first, H.R. 3441, the Save Local Business Act, sponsored by Representative BRADLEY BYRNE. This bipartisan legislation will ensure small businesses and franchises across America receive fair government treatment rather than confusing regulations that harm workers.

Second, the House will consider H.R. 2201, the Micro Offering Safe Harbor Act, sponsored by Representative TOM EMMER. As part of our Innovation Initiative, this bill creates a smarter way for entrepreneurs to start new ventures or grow existing businesses.

Now, lastly, Mr. Speaker, additional legislative items are possible in the House. If anything is added to our schedule, I will be sure to inform my friend and all Members.

Mr. Speaker, I thank my friend for yielding.

Mr. HOYER. Mr. Speaker, I thank my friend for that information.

First, I want to start by saying that the majority leader and I and four other Members of the House had an opportunity to visit both Puerto Rico and the Virgin Islands last weekend since we had our last colloquy.

First, I want to thank the majority leader for organizing that trip and including me on it. It was an eye-opening trip. The majority leader and I have done an op-ed, which will be appearing sometime in the near term, on our observations.

One of the things, Mr. Speaker, that I know the majority leader and I had the opportunity to see, we were in Marathon, where you had housing that was built after Andrew and housing that was built before Andrew.

Now, the difference was, after Andrew, that extraordinary hurricane, the building code was changed. We saw the stark difference between housing that survived essentially Maria and Irma and housing that did not, and the difference was, of course, that the housing that survived was built to different standards after Andrew.

The majority leader and I discussed this matter, along with Mr. BISHOP, who chairs the committee that oversees both Puerto Rico and the Virgin Islands, and I think all of us are convinced that it would be penny-wise and pound-foolish not to build back, as Florida did, to standards that can withstand storms of this type.

So I wanted to thank the majority leader for his leadership on this issue.

The majority leader took the extraordinary effort to climb down a river bank, go across the river—the river was very low at that point in time—and then up a very long ladder, because people were stranded on the other side. The majority leader went to see them and assure them that we would not forget them.

We were the first codel to go to the interior of Puerto Rico, as opposed to simply go to San Juan or another large city, so I thank the majority leader for his leadership on that issue.

Mr. Leader, let me ask you about tax reform. That, of course, has been the big issue for some period of time now, but now we have a bill that is not on the floor yet, but was released yesterday.

It is clear this bill will cut taxes, in our view, for the wealthy. I don't know the statistics yet, what the division is, whether it is 80/20, as the initial proposal was, or perhaps a little less than that that goes to those over $900,000 in income. But, in any event, it also eliminates tax preferences that the middle class families rely on, and, obviously, we think it is going to face hurdles in Congress.

What I wanted to ask was: When does the gentleman expect the bill to be marked up?

Mr. Speaker, I yield to my friend.

Mr. MCCARTHY. Mr. Speaker, I thank the gentleman for yielding, and I am excited about his question, because I am excited about this bill.

For more than three decades, we have waited for tax reform. Many people know the challenge of what they have with the government taking more than they should, and the challenge to see individuals raise their paychecks.

Ways and Means has announced that they will start markups next week. I assume that it will take them probably a week to get through the entire bill, going through regular order as we do, and then I would assume that we would bring that to the floor right after. We would like to get this to the American people as soon as possible.

I am willing to talk about the bill, I am willing to talk about the bill in any different manner, because we spent a lot of time working on this.

The very first thing that is going to happen for the American public, come January 1, they are going to get more in their paycheck, because what we do, we take the standard deduction, because in the current law today, a single individual in America, it is only the first $6,000 they have are tax free. Well, that is going to go to 12. For a couple, it is going to go to 24.

We take seven confusing rates and make it four. It is about cutting them. Every rate is lowered except the highest rate.

Then we go and look at: How can we make America competitive? I started my first business when I was 20 years old. Small business is the backbone of this country. Small businesses work harder than almost anybody else. We lower their rate to 25. That is the lowest it has been in 40 years.

Then all this money that is being pushed overseas that we tax too high so people won't bring it back—and there are trillions of dollars there—we are going to have that money come back. And what are they going to do? They are going to invest in America.

Now, the name of our bill is Tax Cuts and Jobs Act. Just yesterday, I was with a company, Broadcom. We went into the Oval Office. I had worked with this company for quite some time. They started in America. Bell Labs was part of it, and others. Three companies got together. They are technology; they were building; they were growing. Then what they found was, America's Tax Code was so burdensome on them, that for them to compete around the world, they became a company that domiciled in Singapore.

Talking to them just the last month or so, laying out our tax bill, they said: You know what, we are so confident in you passing this, we are going to announce that we are moving back to America.