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# Senate

The Senate met at 12 noon and was called to order by the President pro tempore (Mr. HATCH).

## PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Our Father in Heaven, we sing of Your steadfast love and proclaim Your faithfulness to all generations. Make us one Nation, truly wise, with righteousness exalting us in due season.

Today, inspire our lawmakers to walk in the light of Your countenance. Abide with them so that Your wisdom will influence each decision they make. Lord, keep them from evil so that they will not be brought to grief, enabling them to avoid the pitfalls that lead to ruin. Empower them to glorify You in all they say and do as You fill their hearts with thankful praise. May they never fail to acknowledge their total dependence upon You.

We pray in Your Holy Name. Amen.

## PLEDGE OF ALLEGIANCE

The President pro tempore led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

## RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

## NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2018—MOTION TO PROCEED

Mr. MCCONNELL. Mr. President, I move to proceed to Calendar No. 175, H.R. 2810.

The PRESIDENT pro tempore. The clerk will report the motion.

The bill clerk read as follows:

Motion to proceed to Calendar No. 175, H.R. 2810, a bill to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

The PRESIDENT pro tempore. The majority leader.

### WELCOMING BACK SENATOR MCCAIN

Mr. MCCONNELL. Mr. President, I wish to start this morning with a few words about our friend and colleague from Arizona, Senator MCCAIN, whom we will have an opportunity to welcome back today.

As I noted last week, we all know Senator MCCAIN is a fighter. That is evidenced by his remarkable life of public service, just as it is again evidenced by his quick return to the Senate this afternoon. I know he is eager to get back to work, and we are all very pleased to have him back with us today.

### HEALTHCARE

Mr. President, on the vote we will have today in a couple of hours, Senators will have an important decision to make. Seven years after ObamaCare was imposed on our country, we will vote on the critical first step to finally move beyond its failures.

Many of us have made commitments to our constituents to provide relief from this failed leftwing experiment. Now we have a real opportunity to keep those commitments by voting to begin debate and ultimately to send smarter healthcare solutions to the President's desk for his signature. Just yesterday, the President reiterated his intention to sign them.

Yesterday, the administration released a statement urging all Senators to vote in favor of the motion to proceed so that we can ''move forward on repealing ObamaCare and replacing it with true reforms that expand choice and lower costs.'' I wish to express my appreciation to the administration for its continued close work with us on this issue at every step of the way. From the President and Vice President to Secretary Price and Administrator Verma, as well as so many others, the engagement we have seen has been important to our efforts, and it has sent an unmistakable signal to the country that this administration not only understands the pain middle-class families have felt under ObamaCare but is actually committed to doing something about it.

By now, we are all keenly aware of the pain ObamaCare has caused for literally millions of families. Premiums have skyrocketed, doubling on average in the vast majority of States on the Federal exchange. Insurance options have declined under ObamaCare, leaving many with as few as one or even zero insurers to choose from. Many Americans now face the real possibility of having no options at all and could find themselves trapped, forced by law to purchase ObamaCare insurance but left by ObamaCare without any means to do so. All the while, markets continue to collapse under ObamaCare in States across the country.

It is a troubling indication of what is to come unless we act. Fortunately, the American people have granted us the opportunity to do so. We finally have an administration that cares about those suffering under ObamaCare's failures and a President who will sign a law to actually do something about it. We have a House that recently passed its own legislation to help address these problems. We have a Senate with a great chance before us to do our part now.

If other Senators agree and join me in voting yes on the motion to proceed, we can move one step closer to sending legislation to the President for his signature. I hope everyone will seize the moment. I certainly will. Only then can we open up a robust debate process.

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Only then will Senators have the opportunity to offer additional ideas on healthcare.

Inaction will do nothing to solve ObamaCare's problems or bring relief to those who need it. In fact, it will make things worse for our constituents all across the country.

I wish to reiterate what the President said yesterday:

> Any senator who votes against starting debate is telling America that you are [just] fine with the ObamaCare nightmare. . . .
>
> That's a position that even Democrats have found hard to defend. Remember President Clinton called ObamaCare ''the craziest thing in the world'' and a Democratic Governor said it's ''no longer affordable.''

You won't hear me say this often, but they are right.

I hope colleagues will consider ObamaCare's history of failures—the unaffordable costs, the scarce choices, the burden on middle-class families—as they cast their vote this afternoon. I urge them to remember the families who are hurting under this collapsing law.

Numerous Kentuckians, like so many others across the Nation, have conveyed their heartbreaking stories with my office through phone calls, letters, meetings, and dozen of healthcare forums all across Kentucky. These families are suffering under ObamaCare. They need relief. I will be thinking about them as I vote to proceed to the bill today. I know many other colleagues will do the same.

Our constituents are hurting under ObamaCare. They are counting on us to do the right thing right now. That means voting to allow the Senate to finally move beyond ObamaCare's failures. That is what I intend to do. That is what I urge every colleague to do.

We can do better than ObamaCare. We have a responsibility to the American people to do that. Today's vote to begin debate is the first step, and we should take it.

Mr. President, I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. SULLIVAN). Without objection, it is so ordered.

ORDER OF PROCEDURE

Mr. MCCONNELL. Mr. President, I ask unanimous consent that following my remarks, the Democratic leader be recognized to use his leader time for up to 20 minutes; and that following his remarks, the Senator from Nebraska, Mrs. FISCHER, be recognized to suggest the absence of a quorum.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

RECOGNITION OF THE MINORITY LEADER

The Democratic leader is recognized.

HEALTHCARE

Mr. SCHUMER. Mr. President, in a few short hours, we will vote on the motion to proceed to the House Republican healthcare bill. I will have more to say on the matter prior to the vote.

At the moment, no one knows the plan that is being cooked up in the Republican leader's office, but it seems to be his intention to do whatever it takes to pass anything, no matter how small, to get the House and Senate Republicans into a conference on healthcare.

Surprisingly, I have heard that my friend, the junior Senator from Kentucky, will vote yes on the motion to proceed. He announced it himself. It is true he will likely get a vote on the motion to repeal without replace, but surely he knows that will fail. Why then would the junior Senator from Kentucky—a man who has preached the repeal of the Affordable Care Act root and branch, a man who proselytized that Republicans should stop at nothing short of full repeal—why would the junior Senator from Kentucky vote on the motion to proceed knowing he will not get what he wants? It is because, I believe, he and some of the others in this body know that if the Senate manages to pass something to get to conference in the House, the likely compromise in the conference is either a full repeal of the Affordable Care Act or something close to it. It will certainly mean drastic cuts in Medicaid, huge tax cuts for the rich, no healthcare for those with preexisting conditions, and millions and millions losing healthcare, particularly in our poorer and more brutal States. That is the only thing our Republicans have been able to agree on.

The hard-right Freedom Caucus in the House would never accept a Republican bill that only repeals a few regulations in the ACA but leaves much of it in place. No, they want full repeal, and, at minimum, deep cuts to Medicaid, huge tax breaks for the wealthy, and millions in every State in this Nation losing their healthcare.

To my Republican friends who have repeatedly said that full repeal without replace would be a disaster and to my Republican friends who have opposed the deep and drastic cuts to Medicaid, I say: Don't be fooled by this ruse. A vote in favor of the motion to proceed will mean deep cuts to Medicaid, maybe even deeper than in the House bill. It will mean people with preexisting conditions will be left high and dry. It will mean huge tax breaks for the wealthiest of Americans. It will mean millions will lose their coverage.

So with all the complaining, why are we here at this late moment? Because even the House bill was too drastic for many of the Members here, and it is now being ignored on this motion to proceed, and because we all know the ruse that is going on. The ruse is this: Send it back to the House; then, we will see what they send us. We know what they will send us. We may not know every detail. It will either be full repeal without replace or something far too close to that, and all of the work and all of the anguish that so many of my colleagues on the other side of the aisle have shown in the last several weeks will be wasted because they know darn well what is going to happen when there is a conference.

There are no Democratic votes in the House. The Freedom Caucus calls the shots. They will either ask for full repeal or something very close to it. Make no mistake about it. A vote in favor of the motion to proceed this afternoon will be a permission slip to slash Medicaid, hurt millions, and give huge tax cuts for the wealthy—something the vast majority of Americans in every State, a large percentage of Republicans and Trump voters, abhor.

One last plea to my colleagues: Do not fall for the ruse that the majority leader is putting together. We know what is going on. We all know. Our constituents will not be fooled—oh, no. We on this side are not fooled—oh, no. I hope my colleagues who, out of compassion and care for the people in their States, have made such a fuss up to now will not be fooled either.

COMMENTS OF THE PRESIDENT ON ATTORNEY GENERAL SESSIONS

Mr. President, in recent days, President Trump has gone out of his way to undermine his own Attorney General, his first supporter—what has been reported to be his best friend in the Senate. He has tweeted scathing criticism of Attorney General Sessions and chastised him publicly for recusing himself from the Russia investigation and several other perceived failures, in the eyes of the President.

We should all take a moment to think of how shocking these comments are on a human basis. This is the first person who stuck his neck out for Donald Trump and who was with him through thick and thin. Now, even if the President has disagreements with him—which I think are ill-founded and self-centered and wrong—you don't ridicule him in public—someone who is your close friend. That speaks to character.

But I would like to speak to the major issue before us, which is related. It is clear that President Trump is trying to bully his own Attorney General out of office. How can anyone draw a different conclusion? If President Trump had serious criticisms of his Attorney General, why not talk to him in person? Why air his grievances so publicly? He wants him out. Here is the danger. Many Americans must be wondering if the President is trying to pry open the Office of Attorney General to appoint someone during the August recess who will fire Special Counsel Mueller and shut down the Russia investigation.

First, let me state for the record now, before this scheme gains wings, that Democrats will never go along with the recess appointment if that situation arises. We have some tools in our toolbox to stymie such action. We are ready to use every single one of them at any time, day or night. It is so vital to the future of the Republic.

Second, I cannot imagine that my friends on the Republican side, particularly in the Republican leadership—my friend the majority leader, who I have great respect for, and Speaker RYAN—would be complicit in creating a constitutional crisis. They must work with us and not open the door to a constitutional crisis during the August recess.

SANCTIONS BILL

Mr. President, on one last item, I know there is a lot going on today, but I just want to mention one item from the House of Representatives. Later, the House is going to take up and, hopefully, pass with near unanimity a sanctions bill that includes strong sanctions against Russia, Iran, and North Korea. It is critical that the Senate act promptly on this legislation.

I will work with the majority leader, as I have in recent weeks, to ensure its swift passage so we can get it to the President's desk before we leave for recess.

Thank you, Mr. President.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nebraska.

Mrs. FISCHER. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mrs. FISCHER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. KENNEDY). Without objection, it is so ordered.

## RECESS

Mrs. FISCHER. Mr. President, I ask unanimous consent that the Senate recess until 2:15 p.m. today for the weekly conference meetings.

There being no objection, the Senate, at 12:32 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. PORTMAN).

## NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2018—MOTION TO PROCEED—Continued

The PRESIDING OFFICER. The majority leader.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Democratic leader be recognized for 5 minutes for debate only and that I then be recognized for 5 minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Democratic leader.

HEALTHCARE

Mr. SCHUMER. Mr. President, in a short time, we will vote on the motion to proceed to debate the House Republican healthcare bill. Several months into this new process, with Republicans in the majority in both Chambers, the American people have not been treated to a high-minded debate or to much debate at all.

The very first action of this Congress was for the majority to pass reconciliation instructions on healthcare—a process which has locked out Democrats from the very beginning. The very first thing this Republican Congress said to the American people is that healthcare is going to be a partisan project, undertaken by Republicans and Republicans alone. Right out of the gate, Democrats were locked out. The majority leader elected to forge a bill in secret and bypass the committee process entirely—no public hearings, no open debate, no opportunity for the minority to amend the bill or even to read it before it emerged from the leader's office. Their plan all along was to keep their bill hidden for as long as possible, evade scrutiny, hide the truth from the American people, and then jam the bill through in the dead of night on a party line.

Now, here we are, after so much cloak-and-dagger legislating, about to vote on proceeding to a debate on one of the most important issues of our time—one-sixth of the economy and tens of millions' health and even lives affected without knowing exactly what we will be debating on. Perhaps nothing could sum up the process that has gotten us here quite as well as this. The best the majority leader has been able to cook up is a vague plan to do whatever it takes to pass something—anything—to get the bill to a House and Senate conference on healthcare.

My colleagues, plain and simple, it is a ruse. The likeliest result of a conference between the House and Senate is the full repeal of the Affordable Care Act or something very close to it. It will, certainly, mean drastic cuts in Medicaid, huge tax cuts for the wealthy, no help for those with preexisting conditions, and tens of millions losing healthcare, particularly in poorer and more rural States.

The hard-right Freedom Caucus in the House would never accept a Republican bill that only repeals a few regulations in the ACA but leaves much in place.

I would say to my colleagues, particularly those on the other side of the aisle who have heartfeltly fought hard for not cutting Medicaid drastically, for keeping preexisting conditions, for not giving tax cuts to the rich while you are cutting healthcare for the poor, do not go along with this motion to proceed, because you know and I know what it will lead to. All of the things that you have been trying to avoid will emerge from that conference, and you will hurt the people of your States dramatically.

We all know what is happening here. The leader could not get the votes on a full repeal because it is so damaging to America. He could not get the votes even on his own bill. Instead, the plan is to come up with a proposal that is simply a means to repeal, a means to dramatic cuts, a means to getting us in conference, and we all know what the result of that conference will be.

I would plead one last time with my friends on the other side of the aisle—and I know you have sincerely tried to modify and change things—to turn back. We can go through regular order. We want to work with you. We know that the ACA is not perfect, but we also know that what you have proposed is much worse. We can work together to improve healthcare in this country. Turn back now before it is too late and millions and millions and millions of Americans are hurt so badly in ways from which they will never, ever recover.

I yield the floor.

The PRESIDING OFFICER. The majority leader.

Mr. MCCONNELL. Mr. President, 7 years ago, Democrats imposed ObamaCare on our country. They said that costs would go down. Costs skyrocketed. They said that choice would go up. Choice plummeted. Now ObamaCare's years-long lurch toward total collapse is nearing a seemingly inevitable conclusion, and it will hurt even more Americans on the way down.

This, my friends, is the ObamaCare status quo. This is the status quo. We have had to accept it for a long time. We do not have to accept it any longer.

The American people elected a House with a vision of a better way on healthcare. Then they elected a Senate. Then they elected a President. Now, having been given the responsibility to govern, we have a duty to act. The President is ready with his pen. The House has passed legislation. Today, it is the Senate's turn. That starts with a vote that we will take momentarily. The critical first step in that process is the motion to proceed. It is the vote that determines whether this debate can proceed at all, whether we will even take it up after four straight elections in which this was a huge commitment to the American people. It is the vote that determines whether the Senators of both parties can offer their amendments and ideas on healthcare.

I told the people of my State, over this period, that I would vote to move beyond ObamaCare, and that is what I am going to do today by voting yes. I ask all of my colleagues to join me in doing so. We have already shown that it is possible to put legislation on the President's desk that moves us beyond ObamaCare and its years of failure. We did that 2 years ago. President Obama vetoed what we passed before. President Trump will sign what Congress passes this time.

I thank the President and the administration for all they have done on this issue already. They have worked with us every step of the way, and they, like us, know the consequences of failing to act.

Look, we cannot let this moment slip by. We cannot let it slip by. We have

been talking about this for too long. We have wrestled with this issue. We have watched the consequences of the status quo. The people who sent us here expect us to begin this debate, to have the courage to tackle the tough issues. They did not send us here just to do the easy stuff. They expect us to tackle the big problems. Obviously, we cannot get an outcome if we do not start the debate, and that is what the motion to proceed is all about.

Many of us on this side of the aisle have waited for years for this opportunity and thought that it would probably never come. Some of us were a little surprised by the election last year, but with a surprise election comes great opportunities to do things that we thought were never possible. All we have to do today is to have the courage to begin the debate with an open amendment process and let the voting take us where it will.

That is what is before us, colleagues. Will we begin the debate on one of the most important issues confronting America today? It is my hope that the answer will be yes.

ORDER OF PROCEDURE

Mr. President, I ask unanimous consent that, following the vote, Senator MCCAIN be recognized to speak for debate only for up to 15 minutes and that the time not count on H.R. 1628.

The PRESIDING OFFICER. Without objection, it is so ordered.

## AMERICAN HEALTH CARE ACT OF 2017—MOTION TO PROCEED

Mr. MCCONNELL. Mr. President, I move to proceed to Calendar No. 120, H.R. 1628.

The PRESIDING OFFICER. The clerk will report the motion.

The legislative clerk read as follows:

Motion to proceed to Calendar No. 120, H.R. 1628, a bill to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017.

Mr. MCCONNELL. Mr. President, I ask for the yeas and nays.

(Disturbance in the Visitors' Galleries.)

The PRESIDING OFFICER. The Sergeant at Arms will restore order in the Chamber. The Sergeant at Arms will restore order in the Chamber, please.

(Disturbance in the Visitors' Galleries.)

The PRESIDING OFFICER. The Sergeant at Arms will restore order in the Chamber.

The PRESIDING OFFICER. The question is on agreeing to the motion to proceed.

Mr. MCCONNELL. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The clerk will call the roll.

The senior assistant legislative clerk called the roll.

The yeas and nays resulted—yeas 50, nays 50, as follows:

[Rollcall Vote No. 167 Leg.]

YEAS—50

| | | |
|---|---|---|
| Alexander | Flake | Perdue |
| Barrasso | Gardner | Portman |
| Blunt | Graham | Risch |
| Boozman | Grassley | Roberts |
| Burr | Hatch | Rounds |
| Capito | Heller | Rubio |
| Cassidy | Hoeven | Sasse |
| Cochran | Inhofe | Scott |
| Corker | Isakson | Shelby |
| Cornyn | Johnson | Strange |
| Cotton | Kennedy | Sullivan |
| Crapo | Lankford | Thune |
| Cruz | Lee | Tillis |
| Daines | McCain | Toomey |
| Enzi | McConnell | Wicker |
| Ernst | Moran | Young |
| Fischer | Paul | |

NAYS—50

| | | |
|---|---|---|
| Baldwin | Gillibrand | Murray |
| Bennet | Harris | Nelson |
| Blumenthal | Hassan | Peters |
| Booker | Heinrich | Reed |
| Brown | Heitkamp | Sanders |
| Cantwell | Hirono | Schatz |
| Cardin | Kaine | Schumer |
| Carper | King | Shaheen |
| Casey | Klobuchar | Stabenow |
| Collins | Leahy | Tester |
| Coons | Manchin | Udall |
| Cortez Masto | Markey | Van Hollen |
| Donnelly | McCaskill | Warner |
| Duckworth | Menendez | Warren |
| Durbin | Merkley | Whitehouse |
| Feinstein | Murkowski | Wyden |
| Franken | Murphy | |

The VICE PRESIDENT. As a reminder to our guests, expressions of approval or disapproval are not permitted.

On this vote, the yeas are 50, the nays are 50. The Senate being equally divided, the Vice President votes in the affirmative.

The motion is agreed to.

## AMERICAN HEALTH CARE ACT OF 2017

The VICE PRESIDENT. The clerk will report the bill.

The legislative clerk read as follows:

A bill (H.R. 1628) to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017.

The VICE PRESIDENT. The senior Senator from Arizona is recognized.

ROLE OF THE SENATE

Mr. MCCAIN. Mr. President, I have stood in this place many times and addressed as ''President'' many Presiding Officers. I have been so addressed when I have sat in that chair, and that is as close as I will ever be to a Presidency. It is an honorific we are almost indifferent too; isn't it? In truth, presiding over the Senate can be a nuisance, a bit of a ceremonial bore, and it is usually relegated to the more junior Members of the majority.

But as I stand here today—looking a little worse for wear, I am sure—I have a refreshed appreciation for the protocols and customs of this body and for the other 99 privileged souls who have been elected to this Senate.

I have been a Member of the U.S. Senate for 30 years. I had another long, if not as long, career before I arrived here, another profession that was profoundly rewarding and in which I had experiences and friendships that I revere. Make no mistake, my service here is the most important job I have had in my life. I am so grateful to the people of Arizona for the privilege—for the honor—of serving here and the opportunities it gives me to play a small role in the history of the country I love.

I have known and admired men and women in the Senate who played much more than a small role in our history—true statesmen, giants of American politics. They came from both parties and from various backgrounds. Their ambitions were frequently in conflict. They held different views on the issues of the day. They often had very serious disagreements about how best to serve the national interest.

But they knew that however sharp and heartfelt their disputes and however keen their ambitions, they had an obligation to work collaboratively to ensure the Senate discharged its constitutional responsibilities effectively. Our responsibilities are important—vitally important—to the continued success of our Republic. Our arcane rules and customs are deliberatively intended to require broad cooperation to function well at all. The most revered Members of this institution accepted the necessity of compromise in order to make incremental progress on solving America's problems and to defend her from her adversaries.

That principled mindset and the service of our predecessors who possessed it come to mind when I hear the Senate referred to as the world's greatest deliberative body. I am not sure we can claim that distinction with a straight face today. I am sure it wasn't always deserved in previous eras either. I am sure there have been times when it was, and I was privileged to witness some of those occasions.

Our deliberations today, not just our debates but the exercise of all our responsibilities—authorizing government policies, appropriating the funds to implement them, exercising our advice and consent role—are often lively and interesting. They can be sincere and principled, but they are more partisan, more tribal more of the time than at any time I can remember. Our deliberations can still be important and useful, but I think we would all agree they haven't been overburdened by greatness lately. Right now, they aren't producing much for the American people.

Both sides have let this happen. Let's leave the history of who shot first to the historians. I suspect they will find we all conspired in our decline, either by deliberate actions or neglect. We have all played some role in it. Certainly, I have. Sometimes, I have let my passion rule my reason. Sometimes I made it harder to find common ground because of something harsh I said to a colleague. Sometimes I wanted to win more for the sake of winning than to achieve a contested policy.

Incremental progress, compromises that each side criticizes but also accepts, and just plain muddling through to chip away at problems and to keep

our enemies from doing their worst aren't glamorous or exciting. It doesn't feel like a political triumph. It is usually the most we can expect from our system of government, operating in a country as diverse, quarrelsome, and free as ours.

Considering the injustice and cruelties inflicted by autocratic governments and how corruptible human nature can be, the problem-solving our system does make possible, the fitful progress it produces, and the liberty and justice it preserves, are a magnificent achievement.

Our system doesn't depend on our nobility. It accounts for our imperfections and gives an order to our individual strivings that has helped make ours the most powerful and prosperous society on Earth. It is our responsibility to preserve that, even when it requires us to do something less satisfying than winning, even when we must give a little to get a little, even when our efforts managed just 3 yards in a cloud of dust, while critics on both sides denounced us for timidity, for our failure to triumph.

I hope we can again rely on humility, on our need to cooperate, on our dependence on each other to learn how to trust each other again and, by so doing, better serve the people who elected us. Stop listening to the bombastic loudmouths on the radio and television and the internet. To hell with them. They don't want anything done for the public good. Our incapacity is their livelihood.

Let's trust each other. Let's return to regular order. We have been spinning our wheels on too many important issues because we keep trying to find a way to win without help from across the aisle. That is an approach that has been employed by both sides: mandating legislation from the top down, without any support from the other side, with all the parliamentary maneuvers it requires. We are getting nothing done, my friends. We are getting nothing done.

All we have really done this year is confirm Neil Gorsuch to the Supreme Court. Our healthcare insurance system is a mess. We all know it, those who support ObamaCare and those who oppose it. Something has to be done. We Republicans have looked for a way to end it and replace it with something else without paying a terrible political price. We haven't found it yet. I am not sure we will. All we have managed to do is make more popular a policy that wasn't very popular when we started trying to get rid of it. I voted for the motion to proceed to allow debate to continue and amendments to be offered.

I will not vote for this bill as it is today. It is a shell of a bill right now. We all know that. I have changes urged by my State's Governor that will have to be included to earn my support for final passage of any bill. I know many of you will have to see the bill changed substantially for you to support it. We have tried to do this by coming up with a proposal behind closed doors in consultation with the administration, then springing it on skeptical Members, trying to convince them it is better than nothing—that it is better than nothing—asking us to swallow our doubts and force it past a unified opposition. I don't think that is going to work in the end and probably shouldn't.

The administration and congressional Democrats shouldn't have forced through Congress, without any opposition support, a social and economic change as massive as ObamaCare, and we shouldn't do the same with ours. Why don't we try the old way of legislating in the Senate—the way our rules and customs encourage us to act. If this process ends in failure, which seems likely, then let's return to regular order. Let the Health, Education, Labor, and Pensions Committee, under Chairman ALEXANDER and Ranking Member MURRAY, hold hearings, try to report a bill out of committee with contributions from both sides—something that my dear friends on the other side of the aisle didn't allow to happen 9 years ago. Let's see if we can pass something that will be imperfect, full of compromises, and not very pleasing to implacable partisans on either side but that might provide workable solutions to problems Americans are struggling with today.

What have we to lose by trying to work together to find those solutions? We are not getting much done apart. I don't think any of us feels very proud of our incapacity. Merely preventing your political opponents from doing what they want isn't the most inspiring work. There is greater satisfaction in respecting our differences but not letting them prevent agreements that don't require abandonment of core principles; agreements made in good faith, that help improve lives and protect the American people. The Senate is capable of that. We know that. We have seen it before. I have seen it happen many times. And the times when I was involved, even in a modest way with working on a bipartisan response to a national problem or threat, are the proudest moments of my career and by far the most satisfying.

This place is important. The work we do is important. Our strange rules and seemingly eccentric practices that slow our proceedings and insist on our cooperation are important. Our Founders envisioned the Senate as the more deliberative, careful body that operates at a greater distance than the other body from the public passions of the hour. We are an important check on the powers of the Executive. Our consent is necessary for the President to appoint jurists and powerful government officials and, in many respects, to conduct foreign policy. Whether or not we are of the same party, we are not the President's subordinates, we are his equal.

As his responsibilities are onerous, many, and powerful, so are ours. We play a vital role in shaping and directing the judiciary, the military, and the Cabinet; in planning and supporting foreign and domestic policies. Our success in meeting all these awesome constitutional obligations depends upon cooperation among ourselves.

The success of the Senate is important to the continued success of America. This country—this big, boisterous, brawling, intemperate, restless, striving, daring, beautiful, bountiful, brave, good, and magnificent country—needs us to help it thrive. That responsibility is more important than any of our personal interests or political affiliations. We are the servants of a great nation, ''a . . . nation, conceived in Liberty, and dedicated to the proposition that all men are created equal.'' More people have lived free and prosperous lives here than in any other Nation. We have acquired unprecedented wealth and power because of our governing principles, and because our government defended those principles.

America has made a greater contribution than any other nation to an international order that has liberated more people from tyranny and poverty than ever before in history. We have been the greatest example, the greatest supporter, and the greatest defender of that order. We aren't afraid. We don't covet other people's land and wealth. We don't hide behind walls. We breach them. We are a blessing to humanity.

What greater cause could we hope to serve than helping keep America the strong, aspiring, inspirational beacon of liberty and defender of dignity of all human beings and their right to freedom and equal justice? That is the cause that binds us and is so much more powerful and worthy than the small differences that divide us.

What a great honor and extraordinary opportunity it is to serve in this body. It is a privilege to serve with all of you. I mean it. Many of you have reached out in the last few days with your concern and your prayers. It means a lot to me. It really does. I have had so many people say such nice things about me recently that I think some of you must have me confused with someone else. I appreciate it, though, every word, even if much of it isn't deserved.

I will be here for a few days—I hope managing the floor debate on the Defense authorization bill, which I am proud to say is again a product of bipartisan cooperation and trust among the members of the Senate Armed Services Committee. After that, I am going home for a while to treat my illness. I have every intention of returning here and giving many of you cause to regret all the nice things you said about me, and I hope to impress on you again that it is an honor to serve the American people in your company.

Thank you, fellow Senators.

Mr. President, I yield the floor.

(Applause, Senators rising.)

The PRESIDING OFFICER (Mr. HOEVEN).

The majority leader.

AMENDMENT NO. 267

(Purpose: Of a perfecting nature.)

Mr. MCCONNELL. Mr. President, I call up amendment No. 267.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Kentucky [Mr. MCCONNELL] proposes an amendment numbered 267.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

Mrs. MURRAY. Mr. President, I object.

The PRESIDING OFFICER. Objection is heard.

The clerk will read the amendment.

The legislative clerk continued with the reading of the amendment.

(Disturbance in the Visitors' Galleries.)

The PRESIDING OFFICER. The Sergeant at Arms will restore order in the Gallery.

(Disturbance in the Visitors' Galleries.)

The PRESIDING OFFICER (Mr. STRANGE). The Sergeant at Arms will restore order in the Gallery.

The clerk will continue.

The legislative clerk continued with the reading of the amendment.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

The PRESIDING OFFICER. Who yields time?

If no one yields time, time will be charged equally.

The Senator from Wyoming.

Mr. ENZI. Mr. President, I ask unanimous consent that, for the duration of the Senate's consideration of H.R. 1628, the majority and Democratic managers of the bill, while seated or standing at the managers' desks, be permitted to deliver floor remarks, retrieve, review, and edit documents and send email and other data communications from text displayed on wireless personal digital assistant devices and tablet devices.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ENZI. Mr. President, I ask unanimous consent that the use of calculators be permitted on the floor during the consideration of H.R. 1628.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ENZI. Mr. President, what is the regular order with respect to the pending amendment?

The PRESIDING OFFICER. It is 2 hours equally divided.

Mr. ENZI. Thank you, Mr. President.

I suggest the absence of a quorum and ask unanimous consent that the time be equally divided.

The PRESIDING OFFICER. Is there objection?

Mrs. MURRAY. Objection.

The PRESIDING OFFICER. Objection is heard.

Mr. ENZI. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. NELSON. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

WELCOMING BACK SENATOR MCCAIN

Mr. NELSON. Mr. President, I am so encouraged by the words of our dear friend and fellow Senator, Mr. JOHN MCCAIN.

First of all, I am so encouraged by seeing that fighting spirit of JOHN MCCAIN and so glad to see him back. In the midst of everything he is facing, that he would come and insert himself to give us some considerable words of wisdom—it was such an enormous, emotional experience when JOHN walked in. Then, to have all of us seated here because of the vote that was occurring—and not a Senator left after the vote was concluded because we wanted to hear from JOHN and did so willingly. His eloquent words about how we all need to come together and stop being driven apart by partisan reasons were timely, and they were well received.

Mr. President, this Senator never thought we would see a vote to advance a bill which, to so many, feels as though it is going to harm so many of our fellow Americans. Obviously, we can disagree on specifics, but we have seen that particular expression of opinion of harm over and over. We have seen it in the coverage of the townhall meetings, where people stand up and say: If I didn't have this healthcare, I would be dead.

This Senator has seen it in Florida over and over, as I have had people come up to me wherever I am—in a meeting, on the street corner, in the airport, wherever—and say: Senator, please don't let them take my healthcare away from me.

Indeed, when people explained their particular circumstances, four different families—one family, if they did not have the waiver on Medicaid, indeed, that fellow would not only not be alive, but even if he were alive, he would be in an institution instead of being able to be cared for or three other families who brought forth testimonies about how the Affordable Care Act has given them insurance they had never been able to get before. It was at a price they could afford and involved coverage they never could have had.

In other cases, people had preexisting conditions. This Senator, as a former elected insurance commissioner of Florida, has seen insurance companies refuse to insure people because they had a preexisting condition. If you had asthma, that was a preexisting condition; if you had a bad rash, that was a preexisting condition, and they were not going to insure you. Also, insurance policies never had the guarantee of lifetime coverage but instead the policy said you had lifetime caps. There was a dollar figure which, if you exceeded it, the insurance policy was not going to cover any more.

If we are really serious about wanting to fix the situation, if our brothers and sisters on the other side of the aisle are not successful in proceeding with what the majority leader is going to be coming forth with, if that is voted down, and if we are serious about it, take what is left, which is the existing law—the Affordable Care Act—and fix it.

Senator COLLINS, a former insurance commissioner, appointed in the State of Maine, and this Senator, a former elected insurance commissioner in the State of Florida, are already working on a reinsurance fund which would insure the insurance companies against catastrophe. I asked for this to be costed out in the State of Florida. This fix would lower premiums 13 percent in the State of Florida.

In the words of Senator MCCAIN, if we really want to get together and fix the problems, we can. Yet, in the midst of hearing from constituents all around the country who have shared their personal stories about how the existing law has helped, we are in the parliamentary position we are in, where we will proceed on trying to repeal what is the existing law.

For some people, they don't care about the politics. As a matter of fact, for a lot of people, they don't care about the politics. They just want access to healthcare. They want what is genuinely described as health insurance—whether it is a Medicaid type of insurance or whether it is an actual policy through a private insurance company offered on the health exchanges in the States or whether it is the guarantees of the coverage in an individual policy that they might buy, they just want healthcare. That is the reason you have health insurance in the first place.

Now, I have heard some fixes say: Oh, let's cut back on Medicaid, which, remember, is spread over millions and millions of people, just like Medicare is spread over millions and millions of people. The difference there is age. If you are 65, you are eligible for Medicare.

There are some people we overlook in the system who depend on Medicaid. How about veterans? Veterans' healthcare has been taken care of while on Active Duty in the U.S. military. Then their healthcare is transferred to the Veterans' Administration, but there are a lot of veterans who are not getting their healthcare through the VA. They get their healthcare through Medicaid. If you start cutting back on Medicaid, which are the versions of the so-called replace bills we have seen—if you start cutting back on Medicaid and make a capped program or a block grant program, we already know the figures. It has been costed out by the CBO. The figures tell us it is close to an $800 billion cut over a decade. When you start doing that, the people who rely on Medicaid at the edges, like some poor people or like seniors in nursing homes—by the way, in my

State, 65 to 70 percent of the seniors in nursing homes are on Medicaid, and some of those veterans I told you about are not on VA healthcare but Medicaid. How about some of the children's programs on Medicaid? If you start cutting that back to the tune of about $800 billion over a decade, you are going to knock out a lot of these people. That is not something we want to do. That is why, when explained, you have such low numbers who support what is being attempted as a replacement if you repeal the Affordable Care Act. We should be focused on working together to improve the Affordable Care Act, not to make it worse.

I pretty much have said it all. The bills we have seen coming forth as replacements change the age ratio from the existing law, the Affordable Care Act, of 3 to 1 in the healthcare exchanges so you can charge an older person three times as much as a young, healthy individual—not in the replacement bills we see coming up. It is 5 to 1. What does that mean? That means for those older Americans, before they turn 65 and become eligible for Medicare, they are going to be paying more for their insurance premiums. Is that what we want to do? I don't think so.

You cannot ignore these facts. I ask those who come forth with these replacements, why in the world do you do this? Why do you support a bill that will hurt so many Americans, which has been demonstrated over and over? Why do you support a bill that will hurt so many of your constituents that your constituents cry out to you, please, don't do this? And they give personal testimonies.

I urge our colleagues, after the emotional appeal of Senator MCCAIN, to do things in a bipartisan way. Take a moment, reflect on what your constituents have said—not just some of your constituents. Listen to all of your constituents and ask yourself, are you doing the right thing?

Let's improve our Nation's healthcare system. Let's not make it worse. Let's do it in the spirit of the uplifting words of Senator MCCAIN and what he said: Let's do it together in a bipartisan way.

I yield the floor.

Mr. HATCH. Mr. President, I rise today to once again remind my Senate colleagues what is at stake with the procedural vote that took place today.

The Senate voted on the motion to proceed to the House-passed budget reconciliation bill. The Senate will now start working in earnest to consider and, hopefully, pass legislation that would repeal and replace ObamaCare with a 2-year transition period, or other, specific replacement policies.

That is a complicated undertaking to say the least. However, the first vote on the motion to proceed was relatively simple. While pundits and talking heads have already analyzed this particular vote to death, all of the talk boils down to a single question: Do Republicans want to repeal and replace ObamaCare?

I don't want to belittle or discredit the concerns some of my colleagues have raised about the various legislative proposals that are out there. However, we won't be voting on any particular policy or proposal.

On the contrary, the vote was simply to determine whether the Senate is actually going to consider the budget reconciliation bill. Members were not voting for or against any particular healthcare proposal; they were simply voting on whether the Senate will actually debate any such measure.

That being the case, the vote was a simple one. Anyone who supports the larger effort to repeal and replace ObamaCare should be willing to at least debate the various proposals that have been put forward.

That is the very definition of a no-brainer.

The final pieces of ObamaCare were signed into law in March 2010, more than 7 years ago. Since then, the law has been one of the key focal points of legislative and political debate and discourse nationwide. Very few topics in our Nation's history have been the subject of more public debate and fierce disagreement.

After all this time, one thing is very clear: ObamaCare has failed the American people.

The vast majority of Americans are dissatisfied with the healthcare status quo. These people want answers from Congress that will bring down their healthcare costs, reduce their tax burdens, and put them back in charge of their own healthcare. For more than 7 years now, virtually every Republican in Congress has been promising to provide those solutions.

We have never been closer to making good on those promises than we are right now with a Republican President ready to take action to support congressional efforts to repeal and replace this unworkable law.

Make no mistake, none of the major proposals that have been put forward are perfect. In fact, in my personal view, they are all far from perfect. But, at the end of the day, any bill—particularly a bill as wide and sweeping as one that addresses a large portion of our healthcare system—that is ''perfect'' in the eyes of one Senator is likely fatally flawed in the eyes of 99 others.

Translation: When it comes to legislating successfully, the word ''perfect'' shouldn't be in anyone's vocabulary.

Like any aspect of governing, drafting and passing important legislation is about compromise and prioritization. It is about recognizing which fights need to be fought now and which ones can wait for another day.

I have been here a while. In that time, I have noticed a few things.

Some who are elected to this Chamber would rather fight the good ideological fight for legislative purity than get the majority of what they want—but not everything—through compromise. These people tend to claim that even the most embarrassing legislative losses are victories, so long as they can say that they went down swinging.

Now, don't get me wrong; speaking in terms of advocating good policy I have never been one to back down from a fight. In fact, I have battled some of the most revered and admired Senators in our Nation's history right here on the Senate floor.

One reason I think I have developed a reputation as an effective legislator is I don't believe that fighting for a cause is an end unto itself. Fights are only meaningful if there is an objective in mind. While I am no mathematician, I believe getting 60, 70, or 80 percent of what you want out of a bill is better than getting nothing, even if, on the way to getting nothing, you have fought a valiant fight for that perfect—yet ultimately unattainable—outcome.

The fight to repeal ObamaCare, at least from where I have been standing, has always had an objective in mind. That objective, of course, has been to actually repeal ObamaCare.

We have fought for that objective for more than 7 years. Now, we find ourselves on the cusp of being able to take major steps toward that larger goal.

No, we don't have a perfect bill to vote on. However, the fact remains that we are close to being able to pass legislation that would accomplish the majority of our goals and keep most of the promises we have all made to repeal and replace ObamaCare.

Before we can do any of that, we need to at least get a chance to consider and debate the matter on the floor. That is what this afternoon's vote was to determine: whether we are committed enough to this effort to at least take that step.

I remind my Republican colleagues that, when the ObamaCare reconciliation bill was brought up for debate in 2010, all of our friends on the other side, who were present at the time, except for one Member, voted in favor of the motion to proceed. They supported their leader. Leader MCCONNELL is owed the same loyalty.

Any Senator who has fought with us to undo the damage caused by ObamaCare should be willing, at the very, very least, to take that step and allow the floor debate to actually happen.

I hope we all will. Toward that end, I urged my colleagues to vote in favor of the motion to proceed to the House-passed reconciliation bill to allow the Senate to begin debate on repealing and replacing ObamaCare.

The PRESIDING OFFICER. Who yields time?

If no one yields time, time will be charged equally to both sides.

The PRESIDING OFFICER. The assistant Democratic leader.

Mr. DURBIN. Thank you, Mr. President.

History was made on the floor of the Senate Chamber today. I don't think it

has ever happened before. Think about this: 50 out of 100 Senators came to the floor with the Vice President of the United States and voted to begin debate on a bill they have never seen—a bill they have never seen—because we don't know what the Republicans are going to offer as the alternative to the Affordable Care Act.

There have been a lot of different versions. Technically, the one that is before us now is the version that passed the House of Representatives, but I think the Republican leader, Senator MCCONNELL, has known from the beginning that has no chance whatsoever. So many Republicans have taken a look at what the House passed and said: We can't vote for that. You have to give us something different. The problem the Senate Republicans ran into is that they couldn't come up with anything better.

They tried. They wrote several different versions, and every time they would write a version of the new Affordable Care Act, it got worse for the American people, and here is what I mean. Under one proposal for the Republicans—not the one before us, but the Senate Republicans—1 million people in my home State of Illinois would have lost their health insurance. There are 12.5 million people in Illinois, and 1 million would have lost their health insurance because of dramatic cutbacks in Medicaid and cutbacks in the premium support that is given to a lot of working families to buy regular health insurance in the health insurance market.

It was so terrible that every time Republicans came up with a Senate proposal, two or two of them would announce: Can't buy it, won't vote for it—and ran away from it.

So Senator MCCONNELL came to the floor today and said: I am begging you, just vote to open debate on a bill that I haven't written yet, and 50 Republican Senators did, and the Vice President broke the tie, the 50-to-50 tie to move forward, and here we are.

Let me start by tossing flowers—and this will probably get them in trouble—to two Republican Senators, SUSAN COLLINS of Maine and LISA MURKOWSKI of Alaska. They were the only two Republican Senators who had the courage to stand up and say: This is wrong. We shouldn't do this to the American people. They are the only two who are willing to say that we should have done this differently.

There is an interesting thing that happened at the end of this. At the very last moment, the very last vote that was cast was cast by Senator JOHN MCCAIN. Everybody knows JOHN has been diagnosed with a serious form of cancer. He made it back from Arizona here to cast his vote, and he asked for 15 minutes after the rollcall to make a speech. I don't think many, if any, Senators left the Chamber. Democrats and Republicans stuck around to hear his speech after the vote. Can I tell you that is unusual in the Senate? Most of us race for the doors and go up to our offices and watch on television and may catch a piece of this speech and a piece of the other speech, but we sat and listened because of our respect for JOHN MCCAIN.

He is my friend. We came from the House of Representatives together many years ago. I served with him in the Senate when we put together a bipartisan group to rewrite the immigration laws for America—four Democrats, four Republicans. I sat across the table with JOHN for months. We went back and forth through all the provisions on immigration. JOHN even conceded today that he has an interesting temper. There were days when JOHN MCCAIN was Mount Vesuvius, just exploding in every direction, and you had to step back. And there were days when he smothered you with kindness. That is the way he is. We love him for it.

He came today to give a speech that every American should read if you want to understand how a Democratic Senator can stand on the floor and give compliments and praise to a Republican Senator, which I am about to do. Senator MCCAIN said that we have to do something about this country of ours—the political divisions. I will not get the words perfectly, but he said to us: Will you please start ignoring these radio and TV and internet talking heads who want us to fail and make a living by laughing at us? Will you ignore those people? Instead, look to what this institution, the U.S. Senate, is all about and what we should be doing to solve the problems for the people we represent.

JOHN MCCAIN went on to say: Why don't we have debates on the floor of the Senate anymore?

Do you know what? He is right. We are 7 months into this year's Senate session. We have not had one bill on the floor of the Senate that we have debated and amended—not one. This is a first, and it is in this kind of convoluted reconciliation process where you speed up the amendments.

Think about this. We are amending your healthcare policy that affects you and your family. We are amending how you will buy health insurance as an individual and how your company will buy health insurance for you. We are amending, basically, whether your insurance policy is going to protect your family or not. Listen to how it works.

People propose an amendment, and then we debate it. Do you know how long we debate it? We debate it for 1 minute on both sides. Disgraceful. JOHN MCCAIN called us on it today and asked: Why have we reached this point when an issue this important is going through a process that is totally partisan?

You see, the Republicans decided early on that they were not going to invite us to the party; that they were going to write this healthcare bill by themselves, in secret. Senator MCCONNELL picked 13 Republican Senators, and they sat for I don't know how long—months, weeks—and wrote a bill. One of them I mentioned earlier was ultimately rejected by the Republicans themselves. JOHN MCCAIN challenged us and said: For goodness' sake. He has been in the Senate—and I have too—during a time when it was much different. He really begged us, pleaded, and urged us to get back to that time when we worked together on a bipartisan basis to solve problems. JOHN MCCAIN was right. I did not agree with his vote to put us in this position we are in at this moment, but I was encouraged by the way he closed. He turned to Senator MCCONNELL, who was sitting right there, and said to him: Do not count on my vote on final passage. I want to see what we do in this bill. I want to see how we debate this bill.

One Republican Senator like JOHN MCCAIN can make the difference as to whether this process stops and a real bipartisan process starts. Isn't that what the American people expect of us?

Seated in the Chair, the Presiding Officer, is a brandnew Senator from the State of Alabama.

Welcome, Senator STRANGE.

He comes here because Senator Sessions went on to become the Attorney General. He has seen the Senate for a couple of months or 3 months, maybe—5 months now—and I am sure he has his impressions of this body. They may be different than what he thought about it before he was elected. Yet I can tell him for sure that this is a much different Senate than the one PATTY MURRAY was elected to, that it is much different than the one I was elected to. Even for MIKE ENZI, my friend from Wyoming, it is much different than the one he saw.

I see my colleague here, Senator SCHATZ, from Hawaii.

How long have you been here now, BRIAN?

Mr. SCHATZ. Four-and-a-half years.

Mr. DURBIN. Four-and-a-half years.

He is a newbie, and he has not seen the Senate I am describing.

Can you believe there was a time in the Senate when we would bring an important measure to the floor on many different issues, and Members would come to the floor—I am not making this up—and actually hand an amendment to the clerk and say: I would like to offer an amendment to the bill. Then we would debate it, and then we would vote on it. Sometimes you won, sometimes you lost, and you moved on to the next amendment. That actually happened on the Senate floor. For the people who are new to the Senate, I am sure they do not believe me, but it did happen over and over and over. We had a healthy respect for one another. The amendments went back and forth, and we ended up seeing bills passed that made a difference in America.

What we are doing now is a disgrace to this institution, and it does not honor the Senate, its Members, or our Constitution when what is at stake is

so important. In looking at some of the provisions that have been brought before us in the Senate's Republican repeal bills to repeal the Affordable Care Act, I do not know how they can do it. I do not know how Senators could go home and say in their home States: A million of you are going to lose your health insurance because of something I just voted for.

Health insurance means a lot to me personally. I have said it on the floor. There was a time in my life when I was a brandnew law student and was married. God sent me and my wife this beautiful little baby. She had some health issues, and we had no health insurance, as I was a law student. We ended up sitting in the charity ward of a local hospital here in Washington, hoping our baby girl would have a good, talented, capable doctor walk through the door and see her. I was not sure because I did not have health insurance. I will never forget that as long as I live, and I thought to myself that it will never happen to me again. I am going to have health insurance no matter what it takes. It meant that much to me, and it means that much to everybody.

There is not a single one of us who does not want the peace of mind of knowing that if we get sick or if someone we love gets sick, he will have access to good hospitals and good doctors. That is what health insurance is all about. As the Republican proposals eliminate health insurance for 60 million, 20 million, 30 million Americans, you ask yourself: How can you do that to this country?

The cuts they make in Medicaid have really educated America about Medicaid. People know about Social Security. They know what that is all about. We all pay into it and wait to receive our Social Security checks when we reach that age. They also know about Medicare. You have to be 65 years of age. It is pretty good coverage, isn't it? The ones who receive it think it is a pretty good deal to have Medicare coverage when they reach the age of 65, but Medicaid was one of those mystery programs. People were not sure. What does it do? The Medicaid Program in America does the following:

In Illinois, that program takes care of half of the new mothers and their babies. Half of them are paid for by Medicaid—prenatal care to make sure the baby is healthy, the delivery of the baby. Afterward, the mom and baby are taken care of, paid for by Medicaid. This is one out of every two births in Illinois.

Medicaid also sends provisions—money—to your local school districts. I will bet you did not know that. If your local school district has a special education program—and virtually all of them do—they receive Medicaid to pay for some basics. It pays for counselors for special ed students. Sometimes transportation in a local school district in downstate Illinois or feeding tubes for some severely disabled students are paid for by Medicaid. You may not know that for disabled people, Medicaid is their health insurance. Many of them have no place else to turn.

I mentioned on the floor before that a mother in Champaign, IL, with an autistic child, said: Senator, if it were not for Medicaid, my son would have to go into an institution. I couldn't afford it.

Medicaid is his health insurance.

I have not touched the most expensive part of Medicaid of which you may not know, which is that two out of three people in nursing homes depend on Medicaid to get basic medical care. Medicare is not enough. They need the help of Medicaid. So if it is Mom or Dad or Grandma or Grandpa who is in a nursing home, two out of three of them depend on Medicaid.

The Republican bill to replace the Affordable Care Act says we are going to cut the spending on Medicaid, that 25 to 35 percent will be cut. That is why Governors of both political parties have screamed bloody murder: You cannot do that. You are cutting the Federal contribution to Medicaid in our States. Who is going to pay for that baby? Who is going to pay for the mom? Who is going to pay the school district? Who is going to pay for the disabled? Who will take care of the folks in nursing homes?

Why did they make that deep of a cut in Medicaid—a program that is so important to so many people? There is the tough part. That deep of a cut was made in Medicaid so Republicans, in their healthcare proposal, could include a tax break for the wealthiest people in America, for health insurance companies, and—get this—for pharmaceutical companies. To give them tax breaks, they had to cut Medicaid coverage for all of the people whom I just described.

Is it any wonder that many Republicans backed away from this? Senator HELLER, of Nevada, talked to Governor Sandoval—both Republicans—and said he could not support an early version of the bill because of the deep cuts in Medicaid.

If this is supposed to be an improvement over the Affordable Care Act, which part of it is an improvement? Is it in cutting Medicaid coverage for all of those people, saying that your health insurance policy does not have to cover people with preexisting conditions, raising the cost of healthcare premiums, particularly for people between the ages of 50 and 64, eliminating health insurance for millions? Is that an improvement over the current system? It is not. It is a disaster.

The question is, By the end of this debate, after we have gone through this crazy process of voting up and down quickly and with very little debate, will one more Republican Senator stand up and say unacceptable? Two of them have. If one more will join them, then we can get down to the real business we should face. The real business is being the Senate again with regular order, which means taking the measure to the HELP Committee. Senator MURRAY, of Washington, is the ranking Democrat. Senator LAMAR ALEXANDER is the chairman from Tennessee. I respect him and like him a lot. The two of them ought to have hearings on a bill to change the affordable care system and make it work better, bring down the cost of premiums, and expand health insurance coverage. I think that is what we should be all about.

Now, there is a basic difference in philosophy here. I will close with this, but this is what drives us. Answer the following question, and I can tell you how you are going to vote on this bill:

Do you believe healthcare is a right for every American or do you believe it is a privilege; that if you have enough money and you are lucky enough, you can get it, and if you don't, you go without.

If you answer the question that it is a right, that it should be a right in America, then you have to reject this approach. You cannot take helpless people, some of whom are working hard in two and three jobs at a time and who have no healthcare benefits, and say to them: Sorry. Our system will not take care of you.

One last point. The irony of that is that if you do not give people health insurance, if you do not give them protection, they still get sick, they still go to the hospital, and they still get care. What happens to the bills they cannot pay? Everybody else pays them. Before the Affordable Care Act, each of us paid $1,000 a year in premiums just to cover for the people who could not afford health insurance.

We think there is a better way. We think Americans should have access to affordable health insurance across the board, and we think we can achieve that if we work together on a bipartisan basis. So I hope one more Republican Senator will join Senators COLLINS and MURKOWSKI and bring us back to what JOHN MCCAIN described on the floor today to the Senate—of having a real debate about real issues and really caring about the American people.

I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. BROWN. Mr. President, I ask unanimous consent that after my remarks, the senior Senator from Hawaii be recognized.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BROWN. Mr. President, what is happening today on the Senate floor is outrageous. I still cannot quite believe my colleagues as their staff members stood behind them in the Senate Chamber to my right. All of them have health insurance that is paid for by taxpayers. All of us—all of them, all of the staff, all of the Senators, all of the House Members—have insurance paid for by taxpayers. Yet they would come to the Senate floor with their votes entrusted to them and given to them by

the voting public in their districts and their States. All of them have health insurance that is paid for by the taxpayers, and they would vote to take insurance away from hundreds of thousands of people in my State and in Washington and in Wyoming and in Alabama and in Hawaii.

Millions of people around the country, most of whom have jobs—people who are working $8-, $10-, $12-, $15-an-hour jobs—are not as well paid as the staff who stand behind us as these floor sessions go on, and they would take insurance away from people like them. I am still just incredulous that that would have happened. This bill affects all of our constituents. It would upend one-fifth of the American economy. Yet the people whom we serve have no idea what is in this bill. We really do not know what is in it.

Over the weekend, people said Senator MCCONNELL was going to bring us all to the floor on Tuesday to vote on the healthcare law. This is the law to repeal the Affordable Care Act. I was part of writing the Affordable Care Act as a member of the Health, Education, Labor, and Pensions Committee. That bill took months and months and months, dozens of hearings, and hundreds of amendments. The committee adopted, and I supported, 150 Republican amendments. It was the way we should do things here. Instead, Senator MCCONNELL met just down this hall—I know the camera does not quite show this. Down this hall in his office, he met with lobbyists from Wall Street, with lobbyists from the drug companies, and with lobbyists from the insurance companies. I do not think the Presiding Officer was part of this—he is, perhaps, too junior—but four or five Republican Senators were in there, and they wrote a bill that, alas, was good for drug companies, was good for insurance companies, and was good for Wall Street. It just left out the public.

Now, we do not really know what is in the bill this time. One of the things we do know is, all of the options are bad for my State of Ohio and that all of the options are bad for the people who elected us to serve here. Let me talk about those options.

First, behind door No. 1, we have the repeal of the Affordable Care Act with no replacement. Again, behind door No. 1, I do not know if that is what this bill is. I do know it is one of the options. So behind door No. 1 is repeal with no replacement. That means repealing the entire Affordable Care Act with no plan to replace it. It creates dangerous uncertainty that of course will drive prices up for everyone. When insurance companies, when the people who have insurance now have no idea what is going to happen, of course it drives prices up. Of course, it means insurance companies will pull out of Wyoming and Alabama and Washington State and Hawaii and Ohio.

According to the nonpartisan Congressional Budget Office, 18 million Americans will lose their health insurance next year, and premiums will go up 20 percent. Professionals hold these jobs. They are people who are not Republicans, who are not Democrats, who are just like the Parliamentarian, who is not aligned with either party. The Congressional Budget Office is just like that.

Again, think about that. Think of the Members of the Senate. Think of the Senate's staff who line up along this wall during floor sessions. All of us have insurance. Yet we are going to take it away. According to this plan behind door No. 1, we are going to take it away from 18 million Americans. There would be less coverage, and premiums would go up 20 percent—higher costs. By the end of this decade, 32 million Americans—that is like 1 out of 10 Americans—who currently have insurance would be without health coverage and premiums would double. So 32 million people lose their insurance within the decade and premiums double.

Let's talk about Barbara. Barbara, whom I met in Toledo just recently, is 63. She is not old enough for Medicare; she relies on the healthcare exchanges. Repeal with no replacement would create massive uncertainty for Ohioans.

The people in this body who voted yes today—does the Senate staff who stands behind here who have insurance from—taxpayers like Barbara—do they think about Barbara? Do they think about somebody who reads in the paper that the Senate took the first—still reversible but barely—step toward taking their insurance away? Do they ever think about people like Barbara? Do they, as President Lincoln said, ever get out and get their public opinion pass and listen to people like Barbara? She is 63 years old, and she doesn't know if she will have insurance next month. Imagine that. Do the staff back here, do the Senators who get insurance from taxpayers—do they think: Oh, maybe my insurance won't exist a few months from now. Do they think about that? I am guessing they don't.

Repeal with no replacement creates massive uncertainty for Ohioans like her. We have already seen this year what that uncertainty does to Ohio families, with insurance companies that have been forced to pull out of the market as Congress and the White House create more and more uncertainty. When Aetna pulled out of Dayton and other communities in Ohio—in that part of Ohio—they and others left nearly 20 counties in Ohio without any insurer next year. When they did that, they announced it was because of the uncertainty in this Congress, that nobody really quite knows what is happening.

So that is door No. 1—repeal with no replacement, higher cost, less coverage.

Let's look at door No. 2. Behind door No. 2 is the plan that MITCH MCCONNELL negotiated in secret. As I said, straight down this hall, go to the right, that is MITCH MCCONNELL's office. That is where the drug company lobbyists hung out; that is where the insurance company lobbyists hung out; that is where the Wall Street lobbyists hung out and a small number of Senators, and then they slammed the door shut. That is how they wrote this bill. The Presiding Officer knows this from his constituents in Florida. The drug companies wrote the bill. The insurance companies wrote the bill. Wall Street wrote the bill. And, alas, the bill: tax cuts for insurance companies and tax cuts for the drug companies. The 400 richest families in America—many of them contribute huge numbers of dollars, with lots of zeroes on them, to my Republican colleagues who voted for this bill. The 400 richest families in America will get—under this McConnell door No. 2, there are not just higher costs with less coverage for the public, but 400 families will average a $7 million tax cut for each of the next 10 years. Four hundred families will get a $7 million tax cut for each of the next 10 years.

The McConnell plan would increase healthcare costs for working families. We know that. They would slap on higher costs. They would slap an age tax on Ohioans over 50 when they buy insurance. And when it comes to healthcare costs, Senator HELLER from Nevada said it best: There is nothing in this bill that would lower premiums.

So they give tax cuts to rich people. They give tax breaks to the insurance and the drug companies. They cut Medicaid. But there is nothing in this bill, according to Senator HELLER, a Republican from Nevada, that would lower premiums. There are, however, those massive tax breaks for drug companies that have been jacking up prices on lifesaving medicines like insulin and those drug companies that played a role in creating the opioid epidemic that devastates my State. More people in my State—as the Presiding Officer, who also represents a large State, knows—more people in my State died of opioid overdose than any other State in the United States.

What does this plan do for the opioid epidemic? I have had dozens—maybe not dozens—I have done at least 15 or 20 roundtables around Ohio to talk about the opioid epidemic with doctors and counselors, psychologists and therapists and nurses, people who are recovering from addiction and their families, and others. One thing they all agree on is that the single best tool to help with opioid addiction is, alas, Medicaid. The single best tool to combat the opioid epidemic is Medicaid. This bill would take away the No. 1 tool we have to fight that.

So 220,000 Ohioans right now struggling with opioid addiction, getting treatment for opioid addiction—220,000—they are getting their addiction treatment because they have the Affordable Care Act and insurance provided by the Affordable Care Act. We are going to take that away from them.

At one of my roundtables in Cincinnati—the Talbot House—a father

sitting next to his daughter, who I believe was in her early thirties, looked at me and said: My daughter would be dead from an opioid overdose had it not been for Medicaid expansion. I thank Governor Kasich for having the courage to stand up against his President and stand up against the Republican leadership in this town and do the right thing in expanding Medicaid.

This plan, door No. 2, has higher costs, less coverage, and would kick many of those 220,000 people off their insurance. It would disrupt treatment for hundreds of thousands of Ohioans as they fight for their lives. It would pull the rug out from under local police and communities in the midst of an epidemic.

A number of police officers told me that when they go to a home—a police officer or a firefighter or another first responder—when they go to a home where somebody is unconscious because of an opioid epidemic, first they give them Narcan to revive them, and the second thing they do is sign them up for Medicaid. They sign them up for Medicaid so they can get treatment. Otherwise, there is a very good chance that person will die.

The most important tool for fighting opioid addiction is Medicaid. Yet this body voted today—2 Republicans stood up and voted against this—today, 50 Republicans and the Vice President of the United States, who honored us with his presence today with the tie-breaking vote, voted essentially to kick those people off their treatment.

So door No. 2, the insurance company lobbyist plan: higher costs, less coverage. The same plan written by lobbyists.

Let's talk about door No. 3. Behind door No. 3 are higher costs and less coverage. It is the same plan written by lobbyists, just with taxpayer dollars thrown in to buy off votes. Same result—higher costs and less coverage.

They can't just throw money at this bill and make it better.

Take opioids. They want to take away Medicaid, which is the No. 1 tool we have to get people treated, and then they throw in a $45 billion Federal grant program instead.

Governor Kasich said that those dollars—taking away Medicaid, taking away treatment, taking away insurance from the 700,000 Ohioans in Medicaid expansion and hundreds of thousands of Ohioans later—Governor Kasich is a Republican, and he and I see this pretty much the same way. Governor Kasich said that putting that money in after taking away Medicaid is like spitting in the ocean.

The director of Ohio's Medicaid Program said the Republican Senate plan would be devastating for Ohio. For instance, if someone had cancer, I don't think the best treatment for cancer is to cut off their insurance and then give them a Federal grant to pay their oncologist—not even a Federal grant to pay their oncologist. You don't treat people by a Federal grant, you treat people by insurance and all of the wraparound part of insurance that matters.

It is not just those fighting addiction—I talked a lot about opioids—it is kids with special healthcare needs. It is Ohio schools. There is a program called Medicaid in Schools that helps young people struggling with various kinds of physical and mental illnesses in the schools. That is helpful.

It is rural hospitals. I have been on the phone with literally four dozen hospital CEOs in this State—at least four dozen, a number of them a number of times—and small hospitals in rural communities know that they may close if this bill, the one behind door No. 3, is adopted.

It is seniors in nursing homes, and it is their families who help care for them. Few people realize that three in five nursing home residents in my State rely on Medicaid to cover the cost of their care. That is 60 percent. They are our parents and our grandparents. These are middle-class families and working-class families who end up in nursing homes. They run out of money at the end of their lives. That is Medicaid dollars. Two-thirds of Medicaid dollars don't go to children or opioid addiction, they go to nursing homes to take care of our parents and grandparents.

I met with families again in Toledo last week who rely on Medicaid to help afford nursing home care.

Bob's mother Blanche lives at a home in Perrysburg, a suburb of Toledo.

> My mother and father worked all their lives. My mother is 95 and receives a pension of only $1,500 a month. Medicaid keeps her alive so she is able to spend time with her kids and her grandkids.

I remember Margaret Mead, the great anthropologist, who said that wisdom and knowledge are passed from grandparent to grandchild. A child can spend time with her grandparents, as my daughters got to spend time with their grandparents, especially my grandmother in her last years. It didn't just bring great joy to the grandparents, it imparts wisdom and understanding and education to the grandchildren. Medicaid does that, too, when people have insurance, when people are taken care of in nursing homes and assisted living.

We talk about people like Blanche who worked hard to build a good life for their families. They paid their taxes. They paid their insurance premiums. They paid into Medicare and Social Security. So we are going to cut their Medicaid in the last years of their lives. They shouldn't have to lose everything because they need more intensive care in the later years of their lives, and neither should their families, who are already squeezed—people in their forties and fifties and early sixties—who worry about their children's education on the one hand and then worry about paying for nursing home care for their parents on the other.

Another huge portion of the people Medicaid helps are Ohioans who are workers, who pay taxes, who have children with a disability or with serious special needs. Nearly 500,000 kids in Ohio—20 percent of Ohio kids, 2 in 10—have special healthcare needs. Boaz, whom I met in Cleveland, was born with several heart defects. He wouldn't be alive today without treatment covered by Medicaid. Benjamin Dworning from Akron, born with Down syndrome, visited my office recently with his parents.

It is not just kids with special needs who will lose out. Ohio schools could lose $12 million a year. Twenty-two percent of rural hospitals would be at risk of closing. It goes on and on.

These are all problems created by this bill behind door No. 3, written by lobbyists, written down the hall in Senator MCCONNELL's office by drug company and insurance company and Wall Street lobbyists. That is the bill—undisclosed, unknown until he regurgitated it on the Senate floor and gave us this bill.

Cleveland.com wrote: ''As for the proposed $200 billion to ease the path for ACA funding losses, this too would pale compared with the losses themselves.''

Again, Governor Kasich—he, a Republican; I, a Democrat—said this is spitting in the ocean.

So that is what is behind door No. 3—higher costs, less coverage.

That brings us to door No. 4. What is behind the last door? We have no idea. It is the ultimate mystery plan.

Remember what Washington uncertainty has already done to Ohio families? There are 20 counties with no insurer next year.

As an editor at the Columbus Dispatch—Ohio's most conservative newspaper—said to me about a month and a half ago, uncertainty is like carbon monoxide for business, a silent killer.

Now, the Republican Party, which fashions itself as the party of business, seems to have specialized over the last 10 years in injecting uncertainty into the economy—uncertainties such as, are we going to pass the Export-Import Bank, which Senator MURRAY worked so hard on, so our companies can export American-manufactured, well-made products? Are we going to pay our debts or are we not going to meet our obligations and shut down the government? Are we going to leave hanging out there the Affordable Care Act repeal? All of these things create uncertainty, and as a result, business investment freezes. We know what happens. So who knows what kind of damage this latest vote will do in the insurance market.

What we know for certain is that this mystery plan behind door No. 4 will mean higher costs and it will mean less coverage, because nothing so far—nothing that has been put on the table—could result in anything else. The math doesn't work. How can anyone stand here—again, staff standing by the wall here and Members of the Senate, all getting insurance provided by taxpayers—how can you stand here and

threaten to take away the insurance of others and at the same time drive up costs?

The Affordable Care Act is not perfect. Of course, it is not. We have work to do. Senator SCHUMER talked today about it. Sit down with us. We would love to work through many of the items and get more young, healthy people into the insurance pool, to stabilize the insurance market, to go after the high cost of prescription drugs and maybe, even to consider Medicare at 55. We were one vote away from opening up Medicare in a revenue-neutral way for people between 55 and 64 who might have lost their insurance as they get sick or as they get older. There are all of those options, but don't start with repeal, throwing millions of Americans off of their insurance.

I agree with Governor Kasich one more time. Yesterday, Governor Kasich said: Until Congress can step back from political gamesmanship—which we saw in spades today, as Senator JOHNSON and Majority Leader MCCONNELL were negotiating the last parts of the bill, and as, more or less, 98 of us sat here and watched and wondered what was going on and saw that political gamesmanship—and come together with a workable bipartisan plan, it is a mistake for the Senate to proceed with the vote we just took on Tuesday. He said that yesterday.

Instead of down the hall Senator MCCONNELL working with insurance company and drug company lobbyists, instead of listening to the drug companies so that he puts the tax break for drug companies in the bill, let's listen to the people of Kentucky, Wyoming, Texas, Louisiana, Alabama, North Carolina, Ohio, Hawaii, and Washington. Let's listen to the people of the States of my colleagues in this body.

Let's work on a bipartisan plan to fix what is not working in the Affordable Care Act. Let's keep what is working and make healthcare work better for the people whom we serve.

The PRESIDING OFFICER (Mr. RUBIO). The Senator from Hawaii.

Mr. SCHATZ. Mr. President, how much time remains?

The PRESIDING OFFICER. There is 5½ minutes.

Mr. SCHATZ. Mr. President, we just took one of the most reckless legislative actions in this body's history. We are blowing up the American healthcare system, and we don't even know what comes next.

I want to be clear. The Senate has never before voted on major legislation that would reorder about one-sixth or one-fifth of the American economy and impact millions of lives without actually knowing what the bill would even do.

There has been no bipartisanship. There has been talk of it, but there have been no real discussions. There have been no public hearings. Let me say something about hearings. This is not a technical point. This is the way a legislative body does its work. This is the way we figure out whether our bill is any good or not.

This is the way the Senate has always worked. We don't do major legislation without hearings. But that is what we are doing today, and that is because people don't want to disclose what is in this bill.

It is true that we don't know exactly what is in the bill, but we can be sure of a few things. First, whatever problems there are with the ACA, this bill doesn't even bother to take a swing at them. To the extent people are worried about high deductibles, it will increase the deductibles. To the degree people are worried about the choices on the exchanges, it doesn't even try to solve that problem.

We don't know exactly how much Medicaid will be cut, whether it is just rolling back the Medicaid expansion or making these radical structural reforms, but we know there will be deep cuts to Medicaid. This will hurt people. It will hurt people in nursing homes. It will hurt people with drug addiction. Medicaid is a program that works for tens of millions of Americans, and it will be slashed massively.

We don't know whether they are going to get rid of the capital gains tax or just other revenue, but we know they are going to reduce many of the taxes in the original Affordable Care Act, and they are going to pay for it by cutting Medicaid.

So under the guise of fixing the ACA, they are actually doing nothing about ACA. What they are doing is cutting taxes and cutting Medicaid. We don't know exactly what is in the bill, but we do know that.

People are going to be hurt—people with preexisting conditions, families with loved ones struggling with opioid abuse, people in nursing homes, people who rely on Planned Parenthood, and the tens of millions of people who will lose their insurance almost instantly. That is why every group—from the American Medical Association to the nurses, to the American Cancer Society, to the March of Dimes, to the National Physicians Alliance, and the AARP—opposes this bill. There are 14 different versions of this bill, but, actually, these organizations oppose them all.

There are some core elements of the vote we took that are going to be true no matter what. It will cut Medicaid and cut taxes. It will reduce patient protections. It will reduce the number of people who have insurance.

It was all done with no hearings, with no Democrats, with no experts on healthcare. This thing is going to be dropped on us without enough time to review it and without enough time to interact with our home State and figure out the impact.

Make no mistake, the reason they will not tell you what is going to be in the final bill is because the moment they do, this thing will come crashing down. What the American people have to do is to make sure that this thing comes crashing down anyway. We have to do it for the tens of millions of Americans who depend on Medicaid and the ACA. We have to do it for our rural hospitals. We have to do it for the people with preexisting conditions. We have to do it for the people without power, without money, without the ability to walk 200 yards from this gilded Chamber and get the best healthcare in the world.

I will be fine. All the Members of this Chamber will be fine. But our job is not to take care of ourselves. Our job is to represent our constituents, and this bill has earned the title of most unpopular major bill in American history, most unpopular major legislation in American history.

There is still time to walk back from the brink.

I yield the floor.

The PRESIDING OFFICER. The majority leader.

Mr. MCCONNELL. Mr. President, I ask for the yeas and nays with respect to amendment No. 267.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The majority leader.

AMENDMENT NO. 270 TO AMENDMENT NO. 267

(Purpose: Of a perfecting nature.)

Mr. MCCONNELL. Mr. President, I call up amendment No. 270.

The PRESIDING OFFICER. The clerk will report.

The senior assistant legislative clerk read as follows:

The Senator from Kentucky [Mr. MCCONNELL] proposes an amendment numbered 270 to amendment No. 267.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Is there objection?

Mrs. MURRAY. Mr. President, I object.

The PRESIDING OFFICER. Objection is heard.

The clerk will read the amendment.

The senior assistant legislative clerk continued with the reading of the amendment.

(Mr. DAINES assumed the Chair.)

The bill clerk continued with the reading of the amendment.

(Mr. ROUNDS assumed the Chair.)

The legislative clerk continued with the reading of the amendment.

The senior assistant legislative clerk continued with the reading of the amendment.

The bill clerk continued with the reading of the amendment.

The assistant bill clerk continued with the reading of the amendment.

(Mr. DAINES assumed the Chair.)

The legislative clerk continued with the reading of the amendment.

The senior assistant legislative clerk continued with the reading of the amendment.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. ENZI. Mr. President, I ask unanimous consent that there be 1 hour for debate on amendment No. 270, equally divided between the two managers or their designees; that following the use or yielding back of time, Senator MURRAY or her designee be recognized to make a point of order against the amendment, and that Senator ENZI or his designee then be recognized to make a motion to waive; further, that following the vote on the motion to waive, Senator ENZI or his designee be recognized to offer a second-degree amendment, No. 271, and that Senator MURRAY or her designee be recognized to offer a motion to commit; finally, that the time from 10 a.m. until 12 noon be equally divided between the managers or their designees; that at 12 noon tomorrow, Senator MURRAY or her designee be recognized to make points of order, and that Senator ENZI or his designee be recognized to make a motion to waive; that following the motion to waive, the Senate vote in relation to the amendment No. 271; that following disposition of the amendment, the time until 2:15 p.m. be equally divided on the Murray motion to commit, with a vote on the motion at 2:15 p.m. I further ask that following disposition of the Murray motion, Senator MURRAY or her designee be recognized to offer an additional motion to commit.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. WYDEN. Mr. President, the pitch to Republican Senators this afternoon before the first vote was that it was nothing but a little bit of throat clearing—just a first step to get the conversation started.

Let's be clear, nobody can pretend the stakes aren't real now. In a few minutes, the Senate will be voting on yet another version of the Senate TrumpCare bill. I call it the BCRA 3.0. It features a special gut punch to consumer protection offered by Senator CRUZ.

My view is, the Cruz proposal is a prescription for misery for millions of Americans dealing with serious illness and bedlam in the private insurance market. Forget, colleagues, all the talk about bringing costs down. This bill is going to send health expenses like deductibles and copayments into the stratosphere.

TrumpCare 3.0, BCRA 3.0, tells insurance companies: Look, you are off the hook for basic consumer protection. You get to bring back annual and lifetime caps on coverage, and those caps would hit people who get their healthcare through their employer, as well as those who buy it for themselves in the individual market. You can forget about essential health benefits. You get to flood the market with bargain-basement insurance plans, as long as you offer one, single, comprehensive option, the kind of plan that actually works for people with preexisting conditions and, by the way, you get to price that through the roof.

Under the Cruz proposal, we will be looking at a tale of two healthcare systems in America. The young and healthy are going to opt for the barebones insurance plans that don't cover much of anything, but there are millions of people in this country who cannot get by with skimpy Cruz-plan insurance. They are people who have had a cancer scare or suffer from diabetes. They are people who get hurt on the ski slopes or in a car accident. The only coverage that works for them will come with an astronomical pricetag.

There was no hearing in the Finance Committee, no hearing in the HELP Committee. Senators are flying in the dark, and as far as I can tell, the proposal is going to be before us without having been scored by the CBO.

Let me close with this. It is not too late for Republican Senators to put a stop to this shadowy, unacceptable process. Nobody in this Chamber—not one Senator—has to choose between TrumpCare and straight repeal or any partisan plan. I hope my colleagues will reject TrumpCare 3.0, BCRA 3.0 and say it is time to stop this my-way-or-the-highway process and say, after rejecting this ill-advised amendment, that they would like to return to the regular order, where we look to bipartisan approaches.

I urge my colleagues to oppose and to oppose strongly this first amendment that we will vote on tonight, BCRA 3.0. It is a prescription for trouble for millions of consumers, and I think it is going to cause chaos for the reasons I described in the private insurance market.

I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. PORTMAN. Mr. President, I rise tonight to talk about the Portman amendment and about the broader substitute that repeals and replaces the Affordable Care Act, otherwise known as ObamaCare.

Is this replacement perfect? No. I don't think any replacement is. But it is a big improvement over the status quo. The status quo on healthcare is simply no longer sustainable.

It isn't working for Ohio. We heard a lot about the middle-class squeeze in Ohio, and it is real. Wages are flat and expenses are up. For most folks, the biggest single expense is healthcare costs. It is the fastest growing expense because of higher premiums and higher deductibles.

It wasn't supposed to be this way. In fact, when the Affordable Care Act—ObamaCare—was enacted in 2010, we heard a lot of promises about lower costs. They promised that ObamaCare would bring down premium costs by 2,500 bucks for the average family, but we now know that families have seen their premiums skyrocket. According to the Ohio Department of Insurance, health insurance premiums on the individual market in Ohio have nearly doubled since the Affordable Care Act went into effect 7 years ago. Small business premiums have gone up 82 percent. Premiums for this year are up double-digits, and next year we all expect the same. No one can afford that.

To make matters worse, we have seen a sharp increase in deductibles. For a lot of people covered by insurance, they feel as though they really don't have health care insurance at all because their out-of-pocket expenses are so high and deductibles are so high, they really can't access it.

These higher premiums and deductibles have already made healthcare unaffordable for a lot of hard-working Ohioans. But it is not just about costs, it is also about choice. Some people are losing their coverage altogether because the policies established in the Affordable Care Act were set up for failure.

Fifteen of the 23 nonprofit insurers set up around the country as co-ops around the Affordable Care Act have now gone bankrupt. One was in Ohio. Last year in my State, 22,000 hard-working Ohioans lost their coverage because our co-op declared bankruptcy. Many of them, by the way, had already paid their deductibles on that, and they lost that as well.

Worse than that even, right now there are 19 counties in Ohio without a single insurance company in the exchange market, the individual market—not one insurance company. Another 27 counties in Ohio have only 1 insurer. That is not competition. That is not choice. Far too many Ohioans—thousands of them—if they want health insurance, are told they have to move out of their county to another county.

Less competition has also meant less choices and higher costs for Ohio families and cost shifting on to employer-based plans. As these insurance companies have lost money, some of them haven't left Ohio, but they shifted their costs to other people. That is why so many people's costs have gone up.

Without competition and choice in the market, we are never going to be able to lower healthcare costs for families and small businesses. That is one more reason why the status quo on healthcare, the system we have now, is not sustainable.

The Affordable Care Act has failed to meet the promises that were made, but we can do better, and we have to do better. It is our job to do better, but we should do it in a way that protects low-income beneficiaries of Medicaid, that protects the most vulnerable in our State. We can do that too.

At the outset of this debate and consistently throughout the debate, I have

said my goal was to create a more workable healthcare system that lowers the cost of coverage and provides access to affordable care while protecting the most vulnerable. This most recent version of the Better Care Reconciliation Act—as my colleague just called it, BCRA.3—is an improvement over the House bill, but it is also an improvement over the previous Senate bill. This measure includes reforms that will help lower premiums on families and small businesses. The No. 1 priority out there should be to lower those costs. This bill will help lower those premiums.

Throughout the process, I have expressed my concerns about how we deal with Medicaid, which is a critically important Federal program that provides healthcare benefits to about 70 million Americans who live below the Federal poverty line. The Affordable Care Act allowed States, including Ohio, to expand Medicaid eligibility actually above the poverty line, to 138 percent of poverty, and to cover single adults.

With our growing debt and deficits, we know the current Medicaid Program is not financially sustainable over the long term, and we have to look for innovation and reform to protect and preserve it now so that Ohioans can count on this program in the future and so that those who need it will have it.

My point all along has been that these reforms can and should be done in a way that doesn't pull the rug out from under people and gives States time to adjust. So, in this Senate bill, I have worked to put Medicaid expansion on a glidepath for 6 years, with the current law for 3 years and then a transition for another 3 years. That transition would be to a new healthcare system. This is a big improvement over the House bill, which had a cliff in 2 years without a glidepath.

Just as important, in this substitute before us, Governors would have new flexibility in this legislation to design innovative Medicaid Programs that meet the needs of their States and their expansion populations.

One issue I have focused on a lot in this discussion has been the opioid epidemic. In my own State of Ohio, this epidemic has had a devastating effect. About 200,000 Ohioans now suffer from drug addiction, primarily from heroin and prescription drugs and the new synthetic heroins, such as fentanyl. Unbelievably, I will tell you that about half of the funds we spend in expanded Medicaid in Ohio go for one purpose, and that is mental health and substance abuse treatment, primarily driven by addiction to heroin and prescription drugs and fentanyl.

We have to deal with this issue in a smart way. In this latest version of the substitute, that is why I fought to provide not only that transition for those on expanded Medicaid but also an additional and unprecedented $45 billion in new resources for States to address the opioid epidemic. I am pleased to say that in the legislation we are going to vote on tonight, it is included. We want those receiving opioid treatment under Medicaid expansion to maintain access to treatment as they work to get back on their feet. This new funding is critical to help with regard to that treatment and longer term recovery.

An additional issue I have been working on is to ensure that those on expanded Medicaid are able to find affordable healthcare options under a new system, whether it is under the new Medicaid structure or affordable healthcare options in the private sector on the private market. Over the past few weeks, I have worked with the President, the Vice President, administration officials, and many of my colleagues on ways to improve this bill further in this regard, to help out low-income Ohioans and others who are trying to find affordable coverage. That is why this proposal before us, the Portman amendment, is so important.

By the way, it is called the Portman amendment, but it is the result of the work of a lot of different Senators, some of whom I saw on the floor earlier and one I see here tonight. Senator CAPITO, who has been a leader on this, and Senators HOEVEN, GARDNER, SULLIVAN, CASSIDY, YOUNG, BOOZMAN, HELLER, MURKOWSKI, and others, have worked on this proposal.

I am pleased that we have received a commitment that the Senate will vote tonight on this approach to help those on Medicaid expansion and other low-income Americans get access to affordable healthcare in the private market.

This plan has two parts. First, it provides an additional $100 billion to the long-term stability fund in the Better Care Reconciliation Act to help people with out-of-pocket expenses, such as deductibles and copays, thus ensuring that those who transition from Medicaid expansion into private insurance under a new system not only have the tax credit to help them, which is part of the underlying bill, but also have this additional help for affordable coverage options.

Second, it is a Medicaid wraparound that allows States to provide cost-sharing assistance to low-income individuals who transition from Medicaid to private insurance and receive a tax credit on the exchange. The States could use this flexibility in combination with this long-term stability fund increase—the additional dollars I am talking about—to assist individuals with their deductibles, out-of-pocket expenses, and copays.

It would also allow the States to capture Federal Medicaid matched dollars to supplement the tax credits under the Better Care Act without having to seek and renew existing waiver authority.

This Medicaid wraparound is already available through a waiver, but we think it is critically important to put it in a statute so that other administrators and the current ones—Seema Verma has said she supports this waiver being granted—but others will grant it, and you don't have to renew this waiver or beg for a waiver. It is a commonsense way to help get people who are going into private plans the help they need to be able to afford the premiums, deductibles, and copays.

This is a commonsense approach to help ensure that these low-income Americans have access to affordable care, and I urge my colleagues to support it.

We must do better than the Affordable Care Act. I have heard from people across Ohio on both sides of this debate. Trust me, I have heard a lot. There is a lot of passion. I understand that. But it is interesting, the common denominator in many of these discussions is that doing nothing is not sustainable. Pretty much everybody acknowledges that the status quo is not working. Ohioans deserve action.

In my view, to throw in the towel and give up on finding a better alternative is to give up on Ohio's families, give up on Ohio's small businesses, and I am not willing to do that.

We all know the Affordable Care Act has not lived up to its promises to the American people. Today, after 7 years of consistently calling for repeal and replace, I am supporting a sensible plan to do just that. Is it perfect? No. I don't think any substitute is. Replacement is hard. But it is an improvement on the unsustainable status quo, and it does help keep our promise to the American people to do better.

I urge my colleagues to support the legislation before us.

I yield back my time.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. MARKEY. Thank you, Mr. President.

Mr. President, earlier today the Senate voted on a bill to dismantle this country's healthcare—a cruel bill that would affect every single American and one-sixth of our economy; a heartless bill that was crafted in secret, without public debate and without input from the families who will be impacted; an inhumane bill that would make health insurance unaffordable for millions of Americans and leave millions more with no access at all.

Despite this legislative malpractice, despite numerous independent analyses and nonpartisan Congressional Budget Office findings that millions of Americans will lose coverage and face increased costs, despite Americans from across the country pleading with Republicans not to rip away their coverage or take a machete to Medicaid, despite all that, President Trump and Republican leadership put politics ahead of people and voted to repeal the Affordable Care Act. That is a travesty.

I have often said that the proudest vote of my career was the one I cast in favor of the Affordable Care Act. The second proudest vote is today, voting no on this cruel, heartless, inhumane bill.

To all of my constituents in Massachusetts, please know that I vote no with you in mind.

Massachusetts is the home of universal healthcare. We have a model for the Affordable Care Act. Because of our belief that healthcare is a right and not just a privilege, 98 percent of Massachusetts residents have healthcare coverage. That was a dream of the great Teddy Kennedy, the lion of this Chamber, and it is a reality in Massachusetts.

We cast this historic vote today to proceed to debate on healthcare legislation, but rest assured, the fight to protect the Affordable Care Act is far from over.

It is a testament to how divided the Republican Party is over how to replace the healthcare law that we still don't know which version of TrumpCare we will proceed to vote on for final passage. It is not because Republicans haven't had time—they have had 7 years to craft a plan to repeal the Affordable Care Act. Rather, the chaos we have seen so far from Senate Republicans is because millions of Americans are finally benefiting from insurance coverage, many for the first time, and they don't want these protections taken away.

In many ways, it doesn't matter which bill they bring up for a vote because all versions of the Republican healthcare bill are terrible. Republicans still have no idea how they will go about protecting those with preexisting conditions and ensure that millions aren't kicked off their current insurance plan.

Senate Republicans have so far proposed three bills that would each devastate the healthcare sector, take a machete to Medicaid, and make the poorest in our country pay for tax breaks for the wealthiest. These bills are the bad, the worse, and the ugly.

First, the bad.

Senate Republicans proposed legislation at the end of June—just a month ago—that would rip away health insurance from 22 million Americans and give the top 400 wealthiest people in our country a tax break worth $33 billion.

Then the worse.

They introduced yet another bill that would also kick 22 million Americans off of their health insurance and cut Medicaid by $750 billion. They tried to buy Republican votes with a separate opioid fund, but that craven, political Hail Mary was not fooling anyone.

Then the ugly.

When Republican leadership realized that they did not have the votes for either of these cruel replacement bills, they decided to just repeal the healthcare law without any kind of replacement. This proposal would take coverage away from 32 million Americans and double premiums over the next decade.

That is the slate of Republican healthcare bills—the bad, the worse, and the ugly. All of these healthcare proposals have one thing in common: heartlessness. They all reduce coverage. They all increase costs for Americans. They all eviscerate Medicaid, causing irreparable damage to a program that provides coverage for 70 million Americans, and they all hand over billions in tax breaks to the wealthiest in our country, who do not need them or deserve them. Even in Massachusetts, the Republican proposals would mean more than 260,000 people would lose coverage, often the lowest income residents in the State. It would cost the State more than $8 billion by the year 2025.

There are no changes, no so-called fixes, no modifications to make any of these bills less cruel. Each of the Republican proposals will just exacerbate the most devastating public health crisis facing the country—the battle against opioid overdose deaths.

Leader MCCONNELL said today that he would be thinking about the families who are hurting in Kentucky when he casts his vote to kick at least 20 million Americans off of their health insurance coverage. Yet do you know who will really be hurting? It will be the families of the nearly 1,000 people who died of an opioid overdose in Kentucky last year.

In a blatantly craven attempt to make TrumpCare more palatable, moderate Republicans from States that have been ravaged by the opioid crisis included a paltry opioid fund in the most recent version of the GOP replacement fund. Those are crumbs compared to the amount that the Affordable Care Act would likely spend on covering opioid use disorder treatments if we would just leave the law alone to work as intended. This opioid fund is not a fix; it is a falsehood. It is a false promise to the people who are suffering from opioid addiction. It is a false future that will not include critical Medicaid funding for treatment and recovery services, and it is a false bargain that Republicans will make at the expense of families who are desperate for opioid addiction treatment.

The American people will not be fooled. They realize that opioid funding in this proposal is nothing more than a public health pittance—a wholly inadequate response to our Nation's preeminent public health crisis. No amount of money in an opioid fund can replicate the access to treatment that is provided through the comprehensive health insurance program that the Affordable Care Act represents. Families of those who suffer from substance abuse disorders have been shouting from the rooftops that cutting Medicaid and hamstringing access to health insurance coverage will only make a difficult situation worse.

We should be making health coverage and treatment access more robust, not weaker. Today, only 1 in 10 people with substance addiction receives treatment, and it has been estimated that 2 million people who live with opioid use disorders are not receiving any treatment for their disorders. It should not be a surprise to anyone that the epidemic of opioid abuse will only worsen as long as we have a system that makes it easier to abuse drugs than to get help.

These Republican proposals will be a death sentence for millions of people with substance use disorders. A vision without funding is a hallucination. They are cutting the funding for substance abuse. Republicans are turning their backs on their vow to combat the opioid epidemic, and President Trump is beginning to break his own promise from the campaign trail to ''expand treatment for those who have become so badly addicted.'' Instead, they are moving forward with a proposal that threatens insurance coverage for 2.8 million Americans with a substance use disorder—all to give hundreds of billions in tax breaks to billionaires and big corporations—and slashing funding for our Nation's preeminent public health crisis is just part of it.

Creating a separate fund for opioid use disorders just further stigmatizes the disease and pushes it back into the shadows. This is not how we treat chronic health conditions in this country, and it is insulting to those 33,000 Americans who lost their lives just last year from opioid overdoses.

This latest political maneuver proves yet again that TrumpCare has never been about creating health. It has always been and still is about concentrating wealth—tax breaks for the rich coming from the cuts in healthcare coverage for those who need it the most in our country. They are abandoning hard-working families so that they must fend for themselves while they bestow those gifts of billions in tax breaks to the wealthy. That is shameful.

The GOP replacement plan also imposes an age tax on older Americans, allowing insurance companies to charge older Americans five times more than younger Americans for the same coverage. That is unconscionable.

The GOP plan reduces access to care for those with preexisting conditions—Americans with cancer, diabetes, women who have had children. They want to force them to pay for a Cadillac, but they then hand over to them a tricycle. That is just plain wrong.

On this floor, it is going to be a battle to the very end on this bill, and I am going to keep speaking and keep fighting until my Republican colleagues understand how important these issues are to every single family in our country.

The American people who believe in quality, affordable healthcare will not be silenced by today's vote. Instead, we will be invigorated to call out the callousness in any of these bills that would threaten the economic security for low-income and working families in order to fill the already overflowing bank accounts of the 1 percent. Oh, no. This fight is just beginning out here on the Senate floor because the lives of all

Americans who would be hurt by the Senate's vote today to begin debate on repealing the Affordable Care Act are simply too important for us to stop fighting.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mr. CRUZ. Mr. President, today is an important step in a very long journey. Some 7 years ago, ObamaCare passed into law, and in the 7 years that ObamaCare has been on the books, we have seen the results of this catastrophic law. We have seen the devastation that has resulted. ObamaCare is the biggest job killer in this country.

You and I and the Senators who have listened to their constituents across the country have heard over and over again from small businesses that have been hammered by ObamaCare. As I have listened to small businesses in the State of Texas over and over again, they have described ObamaCare as the single biggest challenge they face.

Indeed, thanks to ObamaCare, we have discovered two new categories of people who have been hurt by the Federal Government—the so-called 49ers and the so-called 29ers. The 49ers are the millions of small businesses that have 47, 48, 49 employees and yet do not grow to 50 because at 50, they would be subject to ObamaCare, and in being subject to ObamaCare, they would go out of business. There are literally millions of new jobs that are waiting to happen, waiting to grow, small businesses ready to expand that ObamaCare penalizes so punitively that they do not expand.

By the way, those jobs that would be the 50th and 51st and 52nd are typically low-income jobs. They are jobs for people who are just starting out in their careers. They are jobs for people who are minorities, who are African Americans, who are Hispanics. They are jobs for people like my father in 1957—washing dishes, making 50 cents an hour, but he was glad to have freedom in this new country.

Then there are the 29ers, the people all across this country who are forcibly put into part-time work at 28, 29 hours a week because ObamaCare defines a ''full-time employee'' as 30 hours a week. People all over the country are being hurt. Single moms who are trying to feed their kids are being hurt because they have been forced into part-time work so that they end up working two or three part-time jobs at 28, 29 hours a piece, and none of them provide healthcare. The burden on them has been enormous.

It hasn't just been jobs, although that is a big part of it; it has also been the millions of Americans who have had their health insurance canceled because of ObamaCare. We all know President Obama looked at the TV cameras and said: If you like your health insurance plan, you can keep your health insurance plan, and if you like your doctor, you can keep your doctor.

PolitiFact—that left-leaning news site—labeled Obama's promise as 2013's Lie of the Year, and it was. It was a deliberate lie, as Jonathan Gruber, the architect of ObamaCare, said that they were banking on what they called the stupidity of the American people—selling it based on a lie.

Then there is the impact on premiums. President Obama promised the American people that under ObamaCare the average family's premiums would drop $2,500 a year. That wasn't just a little bit wrong; it was wildly and dramatically wrong. In fact, the average family's premiums have risen over $5,000 a year.

People are hurting because health insurance is unaffordable. I hear from Texans over and over and over again: I cannot afford health insurance anymore.

I will say that the harms from ObamaCare—the people suffering under this failed law—have been mounting and mounting and mounting, and for 7 years, the Democrats have been content to do nothing. Barack Obama as President and Democrats having majorities in the Senate did nothing for the 49ers who could not get new jobs; nothing for the 29ers, the single moms forced to work part time; nothing for the millions of people who had the insurance plans that they liked canceled; nothing for the millions of people who could not go see their own doctors anymore; nothing for the millions of people whose premiums had skyrocketed.

After 7 years of stonewalling and blockading and saying ''We do not hear you'' to the American people, now our friends on the Democratic aisle are suddenly insisting that they want to do something. Today, we had a vote to take the first step in doing something—in honoring the promise every Republican made to repeal this disaster.

The bill before the Senate is not perfect. No one would expect it to be perfect. Bismarck's comments about sausage-making are certainly true in this process here today. Yet I will say that in the bill before the Senate, which is not likely to pass tonight—but I believe, at the end of the process, the contours within it are likely to be what we enact, at least the general outlines—there are at least four positive elements that are significant.

No. 1, it repeals the individual mandate.

The IRS fines about 6.5 million people a year because they do not have enough money to buy insurance. Think about that for a second. You are struggling to make ends meet, and you do not have the money to buy health insurance. Not only do you not have insurance, but the IRS slaps you with a fine—millions of dollars of fines. In the State of Texas, there are roughly a million people who are getting fined by the IRS, roughly half of whom make $25,000 a year or less and nearly 80 percent of whom make $50,000 a year or less. The Democratic solution is, if you do not have the money for healthcare, the IRS is going to fine you on top of it, and you still do not get healthcare. That is a terrible outcome.

This bill will repeal the individual mandate, repeal the IRS fines on 6.5 million Americans and the job-killing fines of the individual mandate.

It also repeals the employer mandate, which is the driver of the 29ers and 49ers. For 7 years, the Democrats had no answer to the single mom forced to work part time. Repealing the employer mandate provides relief to everyone who finds himself in those camps.

No. 3, this bill has a major reform that allows people to use health savings accounts—pretax money—to pay for insurance premiums. That means, for millions of Americans, their effective premium rates instantly drop 20 to 30 percent by using pretax money. That is a major reform for empowering you, the consumer, to choose the healthcare for your family.

No. 4, the bill before the Senate includes the consumer freedom amendment—an amendment that I have introduced like the health savings account amendment. It is an amendment that says you, the consumer, should have the freedom to choose the healthcare that is best for your family. You should have the freedom. You shouldn't have to buy what the Federal Government mandates that you must buy; you should choose what meets the needs for you and your family.

The consumer freedom amendment was designed to bring together and serve as a compromise for those who support the mandates in title I. The consumer freedom amendment says that insurance companies, if they offer plans that meet those title I mandates—all the protections for preexisting conditions—they can also sell any other plan that consumers desire. So it takes away nothing. If you like your ObamaCare plans, those are still there. It just adds new options and lets you decide: Do you want the ObamaCare option or do you want something else that is affordable? So rather than getting fined by the IRS, you can actually purchase something you and your family can afford.

Now, our friends on the Democratic aisle have been unwilling to look at any option expanding consumer freedom; they just say it won't work. What we know won't work is ObamaCare. We know premiums have risen over $5,000 a year. What happens with the consumer freedom amendment? And this is critical. Over the past 2 weeks, the Department of Health and Human Services conducted a study on the impact of the consumer freedom amendment. They concluded, No. 1, it would expand insurance coverage by 2.2 million people. Our friends on the Democratic aisle are constantly alleging that repealing ObamaCare will reduce coverage. Well, HHS found the consumer freedom amendment expands it by 2.2 million people.

But what does it do to premiums? This is powerful. HHS found that it will reduce premiums by over $7,000 a year. If you are a single mom, if you are a school teacher, if you are a truck-driver, $7,000 a year is a lot of money. It is the difference between making ends meet and not, perhaps. HHS found specifically that for those choosing freedom plans—the less expensive options—premiums would drop $7,260 a year.

But what about those on the exchanges? What about those purchasing plans subject to all of the mandates? HHS found those plans would also drop, they projected by $5,580 a year. So consumers benefit across the board with lower premiums.

This has been a process. At the end of this process, it is not clear what the Senate is going to pass, what is going to bring together and unite the Republican conference because, sadly, the Democrats are not willing to help us provide more consumer freedom, to help us lower premiums, to help us provide relief to the 49ers and 29ers who have been hammered by this bill. But I believe the key to getting this done—and I believe we can and will get to yes. We are not likely to get to yes tonight, but we can and will get to yes. I think the key to it is the consumer freedom amendment, if we are lowering premiums. If Texans, if Montanans, if people across this country are going home and seeing premiums $5,000 a year cheaper with protections for preexisting conditions or $7,000 cheaper if you want a catastrophic plan on a freedom plan, that is a win for everyone. It is a win for conservatives. It is a win for moderates. It should be a win for Democrats. If Democrats were not engaged in this partisan fight, Democrats ought to be saying that lowering premiums $5,000 or $7,000 is a win for our citizens. That, I believe, will be the key to getting this done.

Let me finally say that there is rhetoric about insurance companies. Do you know who loves ObamaCare? It is insurance companies. Under ObamaCare, the profits of the top 10 insurance companies have doubled. When you have the IRS fining people to force them to purchase their product and driving up premiums so they are unaffordable, ObamaCare effectively sets up a cartel for the large insurance companies.

Consumer freedom puts you, the consumer, in charge of your choices. Instead of the giant insurance companies, instead of the Federal Government, it puts you in charge. Freedom is the key to unifying our conference, and lowering premiums is the key, and I believe we can and will get this done.

With that, Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. MERKLEY. Mr. President, we are now considering the Cruz amendment, which he titles consumer freedom, but there could not be a more misnamed amendment to come to the floor.

Americans know this as the fake insurance amendment. This is the amendment that says: Hey, insurance companies, we are going to do you a big favor and let you sell these policies that aren't worth the paper they are written on. And, Hey, isn't this wonderful, says my colleague from Texas, because, you know what, people will only have to pay a few dollars per month for those worthless policies, and that is freedom.

Well, I will tell you that if my colleague had been out talking to people in rural America, as I have been, if he had been out there talking to people in red America, as I have been, he would be hearing that people are terrified about this effort to annihilate health insurance.

One out of three people in Oregon have been able to be on the Oregon Health Plan because of ObamaCare. It has had an incredible impact on our rural healthcare centers. Many of them have doubled their number of employees. About 20,000 employees across the State have been added. Oh, we just heard a speech about it being a job killer, but, in fact, it has employed thousands and thousands more people in the healthcare industry across America. Little communities that didn't have folks being able to take on mental health can now take on mental health issues. Rural communities that didn't have a drug treatment program now have a drug treatment program. Rural hospitals that were going out of business now have a strong financial foundation. And that is just the beginning.

Entrepreneurs across this Nation were tied up in their companies, afraid to leave and pursue their vision because they couldn't get healthcare by themselves. Now, they can, so they are starting one business after another after another after another, and what we have seen is month after month after month of growth in employment in this Nation.

Oh, we can tell you about the amendment that my colleague from Texas is putting forward and what it does in terms of offering these fake policies, but that is only the beginning of it because what it is designed to do is carve off those who are young, carve off those who are healthy, and put them into one pool, and then those with preexisting conditions, those who are sick, those who are older, have to go to another pool in which the rates go way up and create a death spiral. So whether we call this fake insurance for the young and healthy or a death spiral insurance for the old and those with health problems or preexisting conditions, it is really blowing up the insurance market at both ends.

Don't take my word for it; take the experts' word for it. We have a Republican Senator who said that there is a real feeling that there is subterfuge to get around the preexisting conditions, referring to this amendment. And then we have a staffer for a Republican who says: ''And outside health policy folks have said this would set up a death spiral for the markets.''

OK, but let's turn to the American Enterprise Institute, an extremely conservative organization. What does their scholar say? He says, ''This means that people with those kinds of illnesses will end up paying more.'' And then he goes on to say, ''The people who don't know something will happen and come down with something, those are the ones at issue.''

Or let's turn to the American Action Forum Deputy Director Tara O'Neill Hayes, who says: ''I think that really would be the definition of a death spiral.''

Or we can turn to the former CBO Director, Douglas Holtz-Eakin, who says ''What that will do is allow insurers to offer cheap policies to young invincibles. And on the exchange you're going to get all the sick people.''

He continues and says: ''That's a recipe for meltdown. You've split the risk pool into two exchanges.''

And he says: ''I think it would end up being bad politics.''

I am not concerned about bad politics, but I am concerned about those folks whom I have been meeting out in rural America, out in red America, because they are coming to my townhalls and they are saying: Stop this diabolical plan. The Cruz amendment only makes it a lot worse by creating the fake policies for the young and healthy—the young invincibles—and the death spiral insurance for everyone else.

So someone can stand up here and speak glibly about how this is going to fix job creation in America, but what it really says is healthcare for the wealthy—not healthcare, but wealth care.

It is so interesting to see this whole coalition of individuals who want to pass a bill that not only demolishes healthcare for 22 million, but gives hundreds of billions of dollars to the very richest in America. My colleague mentioned a moment ago that the richest 400 families would get $33 billion. No, not $33,000 apiece or $33 million—$33 billion. They feel it is so important to rip healthcare from ordinary working families to deliver benefits to the wealthiest Americans. That is the opposite—opposite—of what we should be doing in America.

Franklin Roosevelt said that the test of our progress is not whether we add more abundance to those who have much; it is whether we do enough for those who have too little. What that translates to is whether we provide a foundation of affordable healthcare so that every family in America has a foundation to thrive. That is what we are fighting for.

This amendment is absolutely a bomb going off in healthcare on both ends of the spectrum, with the young and with the old, with the healthy and

with the sick, and with those with preexisting conditions.

So let's defeat this amendment and make sure we don't make a really terrible bill a lot worse.

The PRESIDING OFFICER. The Senator from Texas.

Mr. CRUZ. Mr. President, unfortunately, there is far too much scaremongering that occurs in the political world. But as John Adams famously said: ''Facts are stubborn things.''

My friend from Oregon just described the consumer freedom amendment as ''a bomb going off in healthcare.'' That is interesting rhetoric, but it is disconnected from the actual facts.

Let's talk about what my friend from Oregon neglected to mention or respond to in any way, shape, or form. He said not a single word about HHS finding that the consumer freedom amendment would expand insurance coverage by 2.2 million people. He had not a word to say in response to that. What he did say is that those who might choose freedom plans would be choosing what he called junk insurance.

Well, it is very nice that ObamaCare mandates that every person must buy a full-fledged Cadillac plan with all the coverage in the world. The problem is, there are millions of people who can't afford it. Not only can they not afford it, they get fined by the IRS because they can't afford it. My friend from Oregon said not a word about the 6.5 million people being fined by the IRS, roughly 50 percent of whom make $25,000 a year or less.

It is interesting that Democrats are advocating fining people who make $25,000 a year or less because they can't afford insurance. And what they say is: Look, we are going to fine you until you can afford to buy the full Cadillac plan. Well, you know what, if you are a young woman, you are 28 years old, you are just starting your career, you are making $30,000 a year, you may not be able to afford the full Cadillac plan, but you might like some coverage. You might like catastrophic coverage. So if you get a cold, you break your arm, you cover that out of your health savings account perhaps. But if, God forbid, you get some terrible disease or hit by a truck, you would like to have an insurance policy.

Sadly, our friends the Democrats say that you are out of luck. If you can't pay for the full-fledged Cadillac, you get nothing. They think your choices are junk insurance.

Remember when Barack Obama said that if you like your insurance plan, you can keep it? Well, listen to how the Democrats have moved today. If they don't like your insurance plan, you can't keep it. If they think your plan is junk, you can't keep it, and they are going to fine you through the IRS. I think you know better what your family wants.

The consumer freedom amendment doesn't take away a single choice. If you like the ObamaCare plans, they are still on the market with all of those mandates. But the Democrats are terrified of freedom. They are terrified that if people actually had the choice, they might not choose the full Cadillac; they might make a different choice.

But then in the world of scaremongering, my friend from Oregon also said: Well, those on the ObamaCare exchanges would go into a death spiral, would see their premiums spike.

Remember that John Adams quote about facts being stubborn things? Here is something else my friend from Oregon ignored, said nothing about. HHS found that for those on the exchanges, with all the title I mandates, including preexisting conditions, their premiums would drop by over $5,500 a year.

So the question is, Who is more trustworthy, the experts at HHS analyzing what would occur with competition and choices in the marketplace or the rhetoric and scaremongering that sadly is being offered from the other side?

It would be one thing if they were confronting facts, if they were actually addressing real facts; instead, it is nothing but angry rhetoric.

My friend from Oregon described repealing ObamaCare and empowering consumers and lowering premiums as ''wealth care.'' Well, there is an irony in that; in that, No. 1, roughly half of the people paying the IRS fines are making less than $25,000 a year. It is the Democrats who are fining low-income people.

No. 2, do you know who agrees with the Democrats on this? The insurance companies. Indeed, my friend from Oregon was reading from the insurance companies. Why have the top 10 insurance companies had their profits double? Because of the Democrats' mandate you have to buy their products. Do you know where the Democrats and the insurance companies agree? None of them want premiums to lower.

Of course, the insurance companies don't want more competition, more options, and your premiums going down. They want to stick it to you as much as they can. Sadly, I don't understand why, but the Democrats are standing arm in arm with the insurance companies, saying their profits need to increase even more. I don't know, maybe they cynically believe eventually it will push it to single-payer socialized medicine. I don't know why they do it, but what is wealth care is ObamaCare fattening the insurance companies at the expense of working men and women.

Facts matter, and if our friends on the Democratic side of the aisle want to raise accusations, they need to stay in the realm of reality and deal with actual facts: You want lower premiums, you want more choices, more options, more competition. You want higher premiums, you want fewer choices, less options, less competition. That is what ObamaCare does, and it is why millions of people are hurting and frustrated. It is why today is an important day.

I yield back the remainder of my time.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. MERKLEY. Mr. President, of course my colleague from Texas made this big rant a little while ago about how ObamaCare is a job killer. When I pointed out it has created jobs all over our country in healthcare, no response. When I pointed out it has created the opportunity for entrepreneurs to create jobs and healthcare jobs, no response. When I pointed out it creates fake insurance that doesn't cover anything when you get sick, no response. All he has to say is that it makes insurance a little cheaper.

Yes, it is worth the paper it is printed on. Well, not even that, actually, because you pay $40 or $50 a month, you go to the hospital, not covered. If you get in an accident and you need an MRI, not covered. You and your spouse have the opportunity and have a child, not covered. Not covered, not covered, not covered. Fake insurance.

It is the experts who say it throws it into a death spiral. It is the experts who say it in conservative think tanks and in liberal think tanks. So what does he have to say? We have something from the Trump team that says it is OK—not a CBO score because he is afraid it will show it makes it worse than the existing bill.

So let's talk about real facts. Next time, don't bring in a political statistic from the Trump team. Let's get a CBO score on this. Then let's have that debate. You had plenty of time to get it and you didn't get it.

This is a terrible amendment. We must defeat it.

Mr. CRUZ. Will the Senator from Oregon yield for a question?

Mr. MERKLEY. I believe my colleague has the remainder of the time.

The PRESIDING OFFICER. The Senator from Washington.

Mrs. MURRAY. Mr. President, despite all Senate Republican leaders' efforts to keep this mean bill hidden from public view, patients and families know the truth.

This legislation would cause families' healthcare costs to spike. It will gut Medicaid, and it will deny tens of millions of people their healthcare coverage. It will defund Planned Parenthood and take away critical healthcare services that women and men rely on, especially in our rural areas where it is already hard enough to get the care you need. TrumpCare would also completely pull the rug out from under patients with preexisting conditions. I could go on.

I hope every one of my colleagues joins me in voting against this awful legislation, but this vote is far from the last time Senate Republicans need to reject TrumpCare, if they are really serious about protecting patients and families from the damage it would do, because if any version of this awful bill leaves the Senate, extreme Republicans in the House are going to do everything they can to make it even

more damaging—and anyone who believes differently is refusing to see the writing on the wall.

I urge my Democratic and Republican colleagues to vote against this bill and every other version of it that we are going to see in the coming hours and days.

Mr. President, I yield back all of our time.

The PRESIDING OFFICER. Is all time yielded back?

The Senator from Washington.

Mrs. MURRAY. Mr. President, I raise a point of order that the pending amendment violates section 311(a)(2)(B) of the Congressional Budget Act of 1974.

The PRESIDING OFFICER. The Senator from Texas.

Mr. CRUZ. Mr. President, pursuant to section 904 of the Congressional Budget Act of 1974 and the waiver provisions of applicable budget resolutions, I move to waive all applicable sections of that act and applicable budget resolutions for purposes of amendment No. 270 and, if adopted, for the provisions of the adopted amendment included in any subsequent amendment to H.R. 1628 and any amendment between Houses or conference report thereon, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The legislative clerk called the roll.

The yeas and nays resulted—yeas 43, nays 57, as follows:

[Rollcall Vote No. 168 Leg.]

YEAS—43

| | | |
|---|---|---|
| Alexander | Flake | Roberts |
| Barrasso | Gardner | Rounds |
| Blunt | Grassley | Rubio |
| Boozman | Hatch | Sasse |
| Burr | Hoeven | Scott |
| Capito | Inhofe | Shelby |
| Cassidy | Isakson | Strange |
| Cochran | Johnson | Sullivan |
| Cornyn | Kennedy | Thune |
| Crapo | Lankford | Tillis |
| Cruz | McCain | Toomey |
| Daines | McConnell | Wicker |
| Enzi | Perdue | Young |
| Ernst | Portman | |
| Fischer | Risch | |

NAYS—57

| | | |
|---|---|---|
| Baldwin | Gillibrand | Murkowski |
| Bennet | Graham | Murphy |
| Blumenthal | Harris | Murray |
| Booker | Hassan | Nelson |
| Brown | Heinrich | Paul |
| Cantwell | Heitkamp | Peters |
| Cardin | Heller | Reed |
| Carper | Hirono | Sanders |
| Casey | Kaine | Schatz |
| Collins | King | Schumer |
| Coons | Klobuchar | Shaheen |
| Corker | Leahy | Stabenow |
| Cortez Masto | Lee | Tester |
| Cotton | Manchin | Udall |
| Donnelly | Markey | Van Hollen |
| Duckworth | McCaskill | Warner |
| Durbin | Menendez | Warren |
| Feinstein | Merkley | Whitehouse |
| Franken | Moran | Wyden |

The PRESIDING OFFICER (Mr. YOUNG). On this vote, the yeas are 43, the nays are 57.

Three-fifths of the Senators duly chosen and sworn not having voted in the affirmative, the motion is rejected.

The point of order is sustained and the amendment falls.

The PRESIDING OFFICER. The Senator from Wyoming.

AMENDMENT NO. 271 TO AMENDMENT NO. 267

(Purpose: Of a perfecting nature.)

Mr. ENZI. Mr. President, I call up the Paul amendment No. 271.

The PRESIDING OFFICER. The clerk will report.

The senior assistant legislative clerk read as follows:

The Senator from Wyoming [Mr. ENZI], for Mr. PAUL, proposes an amendment numbered 271 to amendment No. 267.

Mr. ENZI. I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

The PRESIDING OFFICER. The Senator from Indiana.

MOTION TO COMMIT

Mr. DONNELLY. Mr. President, I have a motion to commit at the desk.

The PRESIDING OFFICER. The clerk will report the motion.

The senior assistant legislative clerk read as follows:

MOTION TO COMMIT WITH INSTRUCTIONS

The Senator from Indiana [Mr. Donnelly] moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) strike provisions that will—

(A) reduce or eliminate benefits or coverage for individuals who are currently eligible for Medicaid;

(B) prevent or discourage a State from expanding its Medicaid program to include groups of individuals or types of services that are optional under current law; or

(C) shift costs to States to cover this care.

Ms. KLOBUCHAR. Mr. President, I ask unanimous consent that the text of my motions to commit be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Klobuchar moves to commit the bill H.R. 1628 to the Committee on Finance of the Senate with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) provide a tax credit to individuals who do not qualify for the credit under section 36B of the Internal Revenue Code of 1986 equal to 25 percent of the premiums for health insurance paid by such individuals during the taxable year.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Klobuchar moves to commit the bill H.R. 1628 to the Committee on Finance of the Senate with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) provide a tax credit to small businesses for each employee enrolled in their health plan who is 50 years of age or older.

MOTION TO COMMIT WITH INSTRUCTIONS

Ms. Klobuchar moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) would help rural hospitals stay open, maintain emergency room care, and provide access to outpatient services.

Ms. KLOBUCHAR. Mr. President, I ask unanimous consent that the text of my motion to commit be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

Ms. Klobuchar moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such committee; and

(2) repeal the noninterference clause under the Medicare part D prescription drug program in order to allow the Secretary of Health and Human Services to negotiate for the best possible price for prescription drugs.

Mr. PETERS. Mr. President, I intend to move to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that,

No. 1, are within the jurisdiction of such committee; and, No. 2, would ensure that the bill does not increase costs, reduce benefits, or eliminate health coverage for any veteran or dependent of a veteran enrolled in traditional Medicaid, expanded Medicaid, or a qualified health plan offered through an exchange.

I am offering this motion because the legislation as written could harm millions of veterans and their dependents currently enrolled in traditional Medicaid, expanded Medicaid, and ACA exchange plans. The following Senators support my motion to commit: DUCKWORTH, STABENOW, CARPER, WHITEHOUSE, SHAHEEN, BLUMENTHAL, HIRONO, REED, DURBIN and BALDWIN. I ask unanimous consent that the full text of my motion to commit be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

Mr. Peters moves to commit the bill H.R. 1628 to the Committee on Finance with instructions to report the same back to the Senate in 3 days, not counting any day on which the Senate is not in session, with changes that—

(1) are within the jurisdiction of such Committee; and

(2) would ensure that the bill does not increase costs, reduce benefits, or eliminate health coverage for any veteran or dependent of a veteran enrolled in traditional Medicaid, expanded Medicaid, or a qualified health plan offered through an Exchange.

The PRESIDING OFFICER. The Senator from Wyoming.

## MORNING BUSINESS

Mr. ENZI. Mr. President, I ask unanimous consent that the Senate be in a period of morning business, with Senators permitted to speak therein for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

## TRIBUTE TO SABRA FIELD

Mr. LEAHY. Mr. President, Vermont is a place of natural, exquisite beauty. From the expansive, rolling Green Mountains, to the crystal shores of Lake Champlain, Vermont is home to some of the most iconic geographic scenery our country has to offer. I am so proud to call Vermont my home.

Vermont is also continually ranked as having the most artists per capita than any other State. Our many artists—writers, photographers, painters, sculptors, potters, and more—help capture the iconic beauty that has long made Vermont a destination for visitors from across the country and around the world. One such artist, Sabra Field, is among the most gifted and extraordinary of them.

Sabra first came to Vermont in 1953 to attend Middlebury College. An Oklahoma native, she has since been lauded as a ''Vermont Living Treasure.'' Perhaps most well-known for her vivid landscapes, Ms. Field's impressive and iconic paintings are now of signature familiarity across our State and beyond. Any Vermonter who sees a painting of purple mountain majesties against a starry, blue night sky knows they are looking at one of her paintings. In 1991, Sabra was commissioned by the U.S. Postal Service to create a postage stamp of a red barn, blue sky, and green hills, a stamp which sold more than 60 million copies. She has also designed images for IBM, the Rockefeller Center, and UNICEF.

Yet what most suspect only to be Ms. Field's effort to capture Vermont's impressive geography may be surprised to discover that the meaning behind her artwork spans much further. In a new exhibit of Sabra's six-decade long career, showcased by the Middlebury College Museum of Art, her artistry takes on a deeper meaning, as told by the artist herself.

The Middlebury exhibit showcases some of Ms. Field's most iconic pieces, with each painting accompanied by a description of the memory or inspiration behind it. For instance, in a caption situated under an illustration of a family of hippopotamuses, Sabra writes of her first child who was hit by a car just short of his 10th birthday and died tragically 2 days later. In a 2011 panorama painted of Hawaii, she captions the story of the passing of her late husband, Spencer, who passed away on his favorite island of Kauai from complications related to cancer. The exhibit also depicts her work beyond that of a pastoralist, with self-portraits and paintings inspired by her personal exploration of spirituality, mythology, the cosmos, world history, and life after death.

These images and others reveal the often somber trials of Ms. Field's life. They also expose the ways in which her artistry has helped her heal and grow over time. Ms. Field is hoping this new exhibit will help avoid her being known as purely a pastoralist, as she feels her art is both an expression of beauty and a representation of the obstacles and rebounds of her life.

Marcelle and I would like to congratulate Sabra on her new exhibit at Middlebury College and on her career of record accomplishments. Her treasured paintings have long been a gift to Vermont and the world, and we know her work's timeless beauty will tell stories for generations to come. Our home proudly displays many of her works of art. We are so proud to call Sabra our dear friend.

I ask unanimous consent that a copy of the article ''Sabra Field Show Reveals Personal Peaks and Valleys,'' published in the Vermont Digger on July 16, 2017, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From Vermont Digger, July 16, 2017]

### SABRA FIELD SHOW REVEALS PERSONAL PEAKS AND VALLEYS

(By Kevin O'Connor)

MIDDLEBURY.—The first words of a new exhibit celebrating one of Vermont's most recognized artists sum up the seeming dilemma: ''What can one say about Sabra Field's work that has not already been said?''

Plenty, the 82-year-old printmaker soon proves. Take her 1962 illustration of a family of sunny, smiling hippos.

''Here is the birth announcement for my first child, Barclay Giddings Johnson III, 'Clay' for short,'' she writes in an accompanying caption. ''He was a handsome boy, a fearless skier, full of the joy of life, loved and admired by adults and kids alike. Hit by a car just short of his 10th birthday, he died two days later.''

Next comes a 1965 self-portrait featuring more shadows than light.

''This is me the year I grew up, age 30,'' she writes, ''when my parents died within a week of each other.''

Then there's the 2011 panorama ''Sea, Sand, Stones'' that Field composed while visiting Hawaii with her husband.

''Spen died suddenly on our favorite island, Kauai, from complications dating back to cancer seven years earlier,'' she writes. ''A set of these prints now hangs in Wilcox Memorial Hospital in Lihue in Spen's memory. The ER doctor who tried so hard to save him has become a good friend.''

Most Vermonters think of Field for works as colorful and carefree as the red barn, blue sky and green hills she created for a 1991 U.S. postage stamp that sold more than 60 million copies.

''Over the course of her career she has received any number of accolades, and has been variously described as 'the Grant Wood of Vermont,' 'the artist laureate of Vermont,' and as someone who 'has touched more lives than any Vermont artist in history,''' says Richard Saunders, a Middlebury College professor and director of its Museum of Art.

But the surprisingly personal ''Sabra Field, Then and Now: A Retrospective'' on campus through Aug. 13 reveals as much about her private struggles as her professional success.

#### ''THE DIRECTION OF ONE'S WISHES''

Field, born in Oklahoma and raised in New York, first came to Vermont in 1953 to attend Middlebury, where she graduated 60 years ago /(''I went to Middlebury because there was no math requirement,'' she confides in the show's catalog). She has given the college an archive copy of every print she has ever created.

Writing her own captions, the artist uses the 100-work exhibit to chronicle her career, starting with a 1971 image of swaying green stripes titled ''Grass.''

''My first 'home run,'' she notes. ''I inadvertently hit a universal theme that got copied and got me to begin registering work with the Library of Congress.''

On another wall, Field's 2001 ''Eastern Mountains'' features a more detailed landscape of emerald, turquoise and gold.

''The trip from coastal Maine to Vermont crosses the White Mountains in New Hampshire and gives a view of the Upper Valley perhaps not as broad and agricultural as in my dreams,'' she writes. ''Memory alters in the direction of one's wishes.''

''Eastern Mountains'' proves the point. Field began the first proofs on Sept. 11, 2001, just before seeing television coverage of that day's terrorist attacks.

Every peak in this artist's world is framed by valleys, the exhibit shows. Consider the 1960 work ''Daisies.''

''This was published as a print and also as a hand-printed greeting card,'' she explains, ''an enterprise found to be hugely unprofitable.''

Next comes a 1969 self-portrait Field produced after leaving her first marriage.

''I divorced and moved from a Connecticut prep school,'' she notes, ''to an old tavern in rural Vermont.''

Then again, every valley in this artist's world is followed by peaks. That two-century-old structure, in the Windsor County settlement of East Barnard, is where Field began to design, draw and cut the woodblock prints that have sustained her for the past 50 years.

''I became part of a different culture where I could live and work at home in a quiet hamlet that was good for kids and without pretense,'' she continues in the caption. ''Here I am sitting in front of my window overlooking a dirt road with alfalfa on the other side and a quote from George Weld on the window frame that reads 'Therefore Choose Life.' ''

#### ''LIKE ARTISTS ALWAYS HAVE BEEN''

Field's subsequent 1972 suite of prints depicting the words of the 23rd Psalm allowed her to mark the death of her firstborn son through images ranging from a wintry day (''Yea, though I walk through the valley of the shadow of death, I will fear no evil'') to a starry summer night (''Surely goodness and mercy will follow me all the days of my life'').

As writer Nancy Price Graff notes in an essay that anchors the exhibit's catalog: ''For the first time, she turned to Vermont's landscape to illustrate humankind's spiritual connection to nature and nature's capacity to heal those who give themselves to it.''

Adds Saunders: ''While on the one hand she has been accused by some of sanitizing the world and removing the nitty-gritty details that surround us, others would say this is a natural part of a desire to see beyond the

mundane and urge us to sense the spiritualism that surrounds us.''

And Field: ''I know I see Vermont through rose-colored glasses. I know what dire poverty we suffer here. But I guess I am like artists always have been. They want to see things at their best.''

As an example, the artist pictures herself in a 1988 self-portrait working in front of a seemingly limitless horizon.

''Reagan started a recession, sales started to slump,'' she confides in the caption. ''An amazing start up, The Mountain School of Milton Academy, hired me to teach gifted high school juniors a few days a week and the commute to Vershire, Vermont, was so beautiful it resulted in many new prints.''

(The self-portrait, its subject adds, features a ''fabulous Ralph Lauren red suede skirt I remembered trying on in New York City'' but ultimately never buying.)

The exhibit includes several landscapes that viewers may recognize from cards, calendars and Vermont PBS pledge drives.

''I believe prints are a popular art form, meant for collectors of modest incomes, as well as those who can spend a lot,'' the artist explains. ''It's been that way since the first woodblock prints were sold to pilgrims as souvenirs at the shrines of Europe in Medieval times.''

But Field's art wasn't always seen as marketable. Take the story behind her 1977 ''Mountain Suite.''

''Vermont Life magazine requested a seasonal suite to sell,'' she writes. ''Then they declined to buy them from me.''

The artist went on to distribute the four images herself. (On her website they now sell for $250 each.) Vermont Life, for its part, profiled her in 1979 and put one of her prints on its cover in 1986.

''LIFE AFTER LIFE? YOU TELL ME''

Success has allowed Field to travel the world and take creative chances. Her 12-panel ''Pandora Suite,'' depicting the Greek myth of the first goddess to appear in human form, came in response to the United States' 2003 invasion of Iraq.

''Her work has changed so much over time,'' the artist's brother, Tony Harwood, says in an hour long documentary, ''Sabra: The Life & Work of Printmaker Sabra Field,'' that plays as part of the show. ''Sabra felt economically comfortable enough to focus on possibly nonmarketable subjects.''

But however far she strays, Field always returns to her roots. Consider the recently completed ''Cloud Way,'' which she deems the retrospective's signature image.

''Believe me when I tell you I did the (preparation) to begin this print while on holiday in Sicily,'' she writes. ''I was homesick for the stretch of the White River along which I travel to reach the coop in South Royalton.''

The show also includes illustrations from her new children's book ''Where Do They Go?''—which the artist, joined by writer Julia Alvarez, will discuss July 29 at Woodstock's Bookstock literary festival.

The latter work ''gently addresses the emotional side of death,'' its publisher states. But Field is aggressive in not letting age stop her creativity. The exhibit features a recent work titled ''Floating Woman.''

''One morning I woke with a dream of floating up to the heavens,'' she writes. ''I walked into the studio and made a little drawing.''

Another self-portrait, she realized.

''Mortality? Resurrection? Life after life? You tell me.''

Field caps her show with a 50-year-old print that quotes the late scribe James Baldwin.

''My future was doubtful that summer of 1967,'' she writes in the caption. ''These words by a black American writer living in Paris described this white American printmaker in New England, and they still do: 'It seems to me that one ought to rejoice in the fact of death, ought to decide indeed to earn one's death by confronting with passion the conundrum of life.' ''

## BUDGETARY REVISIONS

Mr. ENZI. Mr. President, section 3001 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017, allows the chairman of the Senate Budget Committee to revise the allocations, aggregates, and levels in the budget resolution for legislation related to healthcare reform. The authority to adjust is contingent on the legislation not increasing the deficit over the period of the total of fiscal years 2017–2026.

I find that S. Amdt. 267 fulfills the conditions of deficit neutrality found in section 3001 of S. Con. Res. 3. Accordingly, I am revising the allocations to the Committee on Finance, the Committee on Health, Education, Labor, and Pensions, HELP, and the budgetary aggregates to account for the budget effects of the amendment. I am also adjusting the unassigned to committee savings levels in the budget resolution to reflect that, while there are savings in the amendment attributable to both the HELP and Finance committees, the Congressional Budget Office and Joint Committee on Taxation are unable to produce unique estimates for each provision due to interactions and other effects that are estimated simultaneously.

I ask unanimous consent that the tables, which provide details about the adjustment, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

BUDGET AGGREGATES
BUDGET AUTHORITY AND OUTLAYS

(Pursuant to Section 311 of the Congressional Budget Act of 1974 and Section 3001 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017)

| $s in millions | 2017 |
|---|---|
| Current Aggregates: | |
| Spending: | |
| Budget Authority | 3,329,289 |
| Outlays | 3,268,171 |
| Adjustments: | |
| Spending: | |
| Budget Authority | −4,100 |
| Outlays | −4,500 |
| Revised Aggregates: | |
| Spending: | |
| Budget Authority | 3,325,189 |
| Outlays | 3,263,671 |

BUDGET AGGREGATE
REVENUES

(Pursuant to Section 311 of the Congressional Budget Act of 1974 and Section 3001 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017)

| $s in millions | 2017 | 2017–2021 | 2017–2026 |
|---|---|---|---|
| Current Aggregates: | | | |
| Revenue | 2,682,088 | 14,498,573 | 32,351,660 |
| Adjustments: | | | |
| Revenue | −6,200 | −305,300 | −891,500 |
| Revised Aggregates: | | | |
| Revenue | 2,675,888 | 14,193,273 | 31,460,160 |

REVISION TO ALLOCATION TO THE COMMITTEE ON FINANCE

(Pursuant to Section 302 of the Congressional Budget Act of 1974 and Section 3001 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017)

| $s in millions | 2017 | 2017–2021 | 2017–2026 |
|---|---|---|---|
| Current Allocation: | | | |
| Budget Authority | 2,277,203 | 13,101,022 | 31,274,627 |
| Outlays | 2,262,047 | 13,073,093 | 31,233,186 |
| Adjustments: | | | |
| Budget Authority | −200 | −1,000 | 13,600 |
| Outlays | −200 | −1,000 | 13,600 |
| Revised Allocation: | | | |
| Budget Authority | 2,277,003 | 13,100,022 | 31,288,227 |
| Outlays | 2,261,847 | 13,072,093 | 31,246,786 |

REVISION TO ALLOCATION TO THE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

(Pursuant to Section 302 of the Congressional Budget Act of 1974 and Section 3001 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017)

| $s in millions | 2017 | 2017–2021 | 2017–2026 |
|---|---|---|---|
| Current Allocation: | | | |
| Budget Authority | 17,204 | 90,282 | 176,893 |
| Outlays | 15,841 | 89,820 | 183,421 |
| Adjustments: | | | |
| Budget Authority | 400 | −1,000 | −9,200 |

REVISION TO ALLOCATION TO THE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS—Continued

(Pursuant to Section 302 of the Congressional Budget Act of 1974 and Section 3001 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017)

| $s in millions | 2017 | 2017–2021 | 2017–2026 |
|---|---|---|---|
| Outlays | 0 | 500 | −6,000 |
| Revised Allocation: | | | |
| Budget Authority | 17,604 | 89,282 | 167,693 |
| Outlays | 15,841 | 90,320 | 177,421 |

REVISION TO ALLOCATION TO THE UNASSIGNED COMMITTEE

(Pursuant to Section 302 of the Congressional Budget Act of 1974 and Section 3001 of S. Con. Res. 3, the Concurrent Resolution on the Budget for Fiscal Year 2017)

| $s in millions | 2017 | 2017–2021 | 2017–2026 |
|---|---|---|---|
| Current Allocation: | | | |
| Budget Authority | −844,671 | −4,649,869 | −10,724,965 |
| Outlays | −835,437 | −4,608,689 | −10,648,885 |
| Adjustments: | | | |
| Budget Authority | −4,300 | −364,900 | −1,432,100 |
| Outlays | −4,300 | −364,900 | −1,432,100 |
| Revised Allocation: | | | |
| Budget Authority | −848,971 | −5,014,769 | −12,157,065 |
| Outlays | −839,737 | −4,973,589 | −12,080,985 |

## TRIBUTE TO SCOTT ALVAREZ

Mr. CRAPO. Mr. President, today the Senator from Ohio and I wish to speak about Scott Alvarez, general counsel of the Board of Governors of the Federal Reserve System.

Mr. Alvarez is retiring after a 36–year career with the Board of Governors, including the last 12 as general counsel.

He joined the board's legal division in 1981, immediately after graduating from Georgetown Law School, and worked as a staff attorney on bank regulatory issues for many years, until he was named general counsel in 2004.

In that role, he served as a key adviser to Chairmen Greenspan and Bernanke and Chair Yellen.

He was also general counsel of the Federal Open Market Committee, and he was the chief lawyer in carrying out some of the Fed's other roles, including overseeing the payments system and issuing currency.

I have enjoyed working with Mr. Alvarez over the years and have appreciated the insights and feedback he has provided to me and the Banking Committee.

On a personal note, his help was particularly valuable in 2006, when the Senate passed the Financial Services Regulatory Relief Act of 2006, which was then signed into law by President Bush.

I want to thank Mr. Alvarez for his assistance on that bill and others and for his service to the Federal Reserve and to the country.

Mr. BROWN. Mr. President, I want to echo the comments of the senior Senator from Idaho, the chairman of the Banking Committee, and thank Mr. Alvarez for his service at the Federal Reserve.

I specifically want to thank him for his service during the financial crisis of 2008. Our country faced daunting challenges during that period, and the Federal Reserve and the government's response to the financial crisis was not an easy undertaking.

The crisis demanded great effort and ingenuity from many people. It required close coordination across the executive branch, the regulatory agencies, Congress, and the private sector. Working with key decisionmakers at the board and throughout the government, Mr. Alvarez played an important role in developing and articulating the legal dimensions to virtually every initiative taken by the Federal Reserve to address the crisis.

Mr. Alvarez also worked closely with Congress during consideration of the Dodd-Frank Wall Street Reform and Consumer Protection Act and played a crucial role in implementing rulemakings required of the Federal Reserve by Dodd-Frank. I am particularly grateful for the work he did to implement strong rules to increase the capital and leverage requirements for the Nation's largest banks—a necessary and critical step after the crisis—and the work that he did with my office in making one of the first substantive amendments to Dodd-Frank related to capital standards for insurance companies.

Scott Alvarez has served the Federal Reserve and the American people with great distinction and deserves thanks for a job well done.

# ADDITIONAL STATEMENTS

## TRIBUTE TO DR. TEMPLE GRANDIN

● Mr. GARDNER. Mr. President, today I wish to honor Dr. Temple Grandin's induction into the National Women's Hall of Fame. Dr. Grandin is an internationally recognized leader for her work in animal sciences and autism awareness. I would also like to wish Dr. Grandin a happy 70th birthday.

Dr. Grandin has contributed immensely to the study of animal sciences and the agriculture industry. She has been an esteemed college professor at Colorado State University for more than 20 years, and much of her research and inventions have become standard industry procedure, like humane cattle slaughter. She began her career in the early 1970s and was one of only a handful of women working in animal sciences. She paved the way for other women to thrive in this industry.

In addition to her professorship, Dr. Grandin has become a well-known advocate and spokeswoman for autism awareness. She has published countless books about living with autism and has been recognized on the Time Magazine's Top 100 Most Influential People under the ''Heroes'' category. She has received honorary doctorate degrees from 13 universities across the country and around the world. Dr. Grandin has also received numerous industry awards for her significant contributions to agriculture, as well as her advocacy for autism awareness.

Dr. Grandin has undoubtedly left a lasting impression on the animal sciences and autism advocacy. I congratulate her induction into the prestigious National Women's Hall of Fame and again wish Dr. Grandin a very happy birthday.●

## TRIBUTE TO JAKOB HELLER

● Mr. HELLER. Mr. President, today I wish to recognize my nephew, Jakob Heller, on his upcoming achievement of becoming an Eagle Scout, one of the highest honors in the Boy Scouts. On August 2, 2017, Jakob officially becomes an Eagle Scout, which serves as a symbol of his dedication to the Scouts' mission of creating responsible, participating citizens and leaders.

In order to become an Eagle Scout, Jakob completed tests and earned merit badges that required mastering specific outdoor skills and providing services to his community. He also demonstrated a commitment to his team and the Boy Scout mission and oath.

Jakob comes from a military family, and like many military families, they are constantly on the move. Jakob's father served in the U.S. Navy, and after retirement, he moved his family to southern West Virginia where they have been living for the last 5 years. I am happy to note that, following his Eagle Scout ceremony, Jakob and his family will be moving to Carson City, NV, where his grandparents and extended family anxiously await his arrival.

Jakob is a talented young man who excels academically and participates in a number of extracurricular activities. In addition to his academic accomplishments, he is a gifted musician who

plays the trumpet in the marching band and the French horn in the school's concert band. He is also a member of the cross-country team and participates in track and field, where he shines in sprint relays, hurdle events, and the long jump. His ability to balance school, athletics, and Boy Scouts is truly remarkable.

Furthermore, Jakob is preparing for a future in computer programming. Like many kids his age, he loves playing video games and is interested in becoming a video game programmer. Additionally, he is part of his school's robotics club and programs robots to compete in challenging competitions. With such extensive experience at a young age, I am confident Jakob will have a bright future as a computer programmer.

Jakob is responsible and dependable and understands the importance of his family, friends, and community. Boy Scouts has had a positive impact on his life, and I know that he will serve as an excellent role model for other members of his family and friends.

In closing, I ask my colleagues and all Nevadans to join me in congratulating this new Nevada resident, my nephew Jakob Heller. I cannot be more proud of this young man, and I look forward to witnessing his many contributions to our community in the years ahead.●

## TRIBUTE TO PAUL KASTER

● Mr. ROBERTS. Mr. President, today I wish to recognize the distinguished accomplishment of Kansan Paul Kaster on the occasion of his 2017 National Federation of Independent Business, NFIB, Young Entrepreneur Award.

Mr. Kaster, of Leawood, KS, is the founder and owner of Crooked Branch Studio, which specializes in woodworking. I ask that my colleagues join me in recognizing Paul on his outstanding achievements. I wish him nothing but the best for his future entrepreneurial and educational endeavors.●

## MONROE COUNTY BICENTENNIAL

● Ms. STABENOW. Mr. President, today I wish to pay special tribute to Monroe County, MI, which is celebrating its bicentennial this year.

Located on the shores of Lake Erie, Monroe County was founded on July 14, 1817. It is named in honor of President James Monroe, who visited the Michigan Territory in August 1817, shortly after the county's founding. The county has the proud distinction of being the second county founded in Michigan.

The people of Monroe are proud of their history. This history has inspired generations of hard-working and fiercely independent people who are committed to preserving their history, protecting their natural resources, and innovating for their future.

Monroe County is home to the River Raisin National Battlefield Park, which commemorates the January 1813 battles of the War of 1812. The battles marked one of the greatest defeats for the United States during the war, and the rally cry, ''Remember the Raisin'' inspired support for the rest of the war. I was honored to help lead the effort in Congress with Congressman Dingell and Senator Levin to pass the legislation that made the park part of the National Park System. The park has now become an economic driver, attracting economic development to the surrounding area.

Monroe County is also home to La-Z-Boy Furniture, the inventers of the world's first reclining chair. The company was founded in 1927 and employs more than 6,300 people nationwide. The corporate headquarters is still based in Monroe.

One of the most famous Monroe County residents is General George Armstrong Custer, who spent much of his life in Monroe. One of the youngest Americans to ever be promoted to brigadier general, Custer is known for his successes during the Civil War and his death at the Battle of the Little Bighorn, also known as Custer's Last Stand.

As a leader of the Senate Agriculture Committee, I am especially proud of Monroe County's agricultural heritage. The county has over 270 historic farms—the most of any county in Michigan.

Numerous events and celebrations have been planned in the county throughout the year to mark this special milestone. Congratulations to Monroe County on 200 years of impressive history, growth, and success.●

## TRIBUTE TO DEVIN MARTIN

● Mr. THUNE. Mr. President, today I recognize Devin Martin, one of my Washington, DC, interns, for all of the hard work he has done for me and my staff at the Senate Republican Conference.

Devin is a graduate of Huntley High School in Huntley, IL. Currently, he is attending the University of South Dakota in Vermillion, SD, where he is majoring in journalism and political science. Devin is a dedicated worker who has been committed to getting the most out of his experience.

I extend my sincere thanks and appreciation to Devin Martin for all of the fine work he has done and wish him continued success in the years to come.●

## MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Ridgway, one of his secretaries.

## EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The messages received today are printed at the end of the Senate proceedings.)

## MESSAGES FROM THE HOUSE

At 12:29 p.m., a message from the House of Representatives, delivered by Mr. Novotny, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 282. An act to amend the Servicemembers Civil Relief Act to authorize spouses of servicemembers to elect the same residences as the servicemembers.

H.R. 1058. An act to amend title 38, United States Code, to clarify the role of podiatrists in the Department of Veterans Affairs, and for other purposes.

H.R. 1690. An act to amend title 38, United States Code, to require the Secretary of Veterans Affairs to submit an annual report regarding performance awards and bonuses awarded to certain high-level employees of the Department of Veterans Affairs.

H.R. 1848. An act to direct the Secretary of Veterans Affairs to carry out a pilot program on the use of medical scribes in Department of Veterans Affairs medical centers, and for other purposes.

H.R. 2006. An act to amend title 38, United States Code, to improve the procurement practices of the Department of Veterans Affairs, and for other purposes.

H.R. 2056. An act to amend the Small Business Act to provide for expanded participation in the microloan program, and for other purposes.

H.R. 2333. An act to amend the Small Business Investment Act of 1958 to increase the amount of leverage made available to small business investment companies.

H.R. 2364. An act to amend the Small Business Investment Act of 1958 to increase the amount that certain banks and savings associations may invest in small business investment companies, subject to the approval of the appropriate Federal banking agency, and for other purposes.

H.R. 2749. An act to amend title 38, United States Code, to improve the oversight of contracts awarded by the Secretary of Veterans Affairs to small business concerns owned and controlled by veterans, and for other purposes.

H.R. 2781. An act to direct the Secretary of Veterans Affairs to certify the sufficient participation of small business concerns owned and controlled by veterans and small business concerns owned by veterans with service-connected disabilities in contracts under the Federal Strategic Sourcing Initiative, and for other purposes.

H.R. 3218. An act to amend title 38, United States Code, to make certain improvements in the laws administered by the Secretary of Veterans Affairs, and for other purposes.

The message further announced that the Clerk of the House of Representatives request the Senate to return to the House the joint resolution (H.J. Res. 76) granting the consent and approval of Congress for the Commonwealth of Virginia, the State of Maryland, and the District of Columbia to a enter into a compact relating to the establishment of the Washington Metrorail Safety Commission.

At 5:34 p.m., a message from the House of Representatives, delivered by

Mr. Novotny, one of its reading clerks, announced that the House has passed the following joint resolution, in which it requests the concurrence of the Senate:

H.J. Res. 111. Joint resolution providing for congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by Bureau of Consumer Financial Protection relating to ''Arbitration Agreements''.

## MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 282. An act to amend the Servicemembers Civil Relief Act to authorize spouses of servicemembers to elect to use the same residences as the servicemembers; to the Committee on Veterans' Affairs.

H.R. 1058. An act to amend title 38, United States Code, to clarify the role of podiatrists in the Department of Veterans Affairs, and for other purposes; to the Committee on Veterans' Affairs.

H.R. 1690. An act to amend title 38, United States Code, to require the Secretary of Veterans Affairs to submit an annual report regarding performance awards and bonuses awarded to certain high-level employees of the Department of Veterans Affairs; to the Committee on Veterans' Affairs.

H.R. 1848. An act to direct the Secretary of Veterans Affairs to carry out a pilot program on the use of medical scribes in Department of Veterans Affairs medical centers, and for other purposes; to the Committee on Veterans' Affairs.

H.R. 2006. An act to amend title 38, United States Code, to improve the procurement practices of the Department of Veterans Affairs, and for other purposes; to the Committee on Veterans' Affairs.

H.R. 2056. An act to amend the Small Business Act to provide for expanded participation in the microloan program, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H.R. 2333. An act to amend the Small Business Investment Act of 1958 to increase the amount of leverage made available to small business investment companies; to the Committee on Small Business and Entrepreneurship.

H.R. 2364. An act to amend the Small Business Investment Act of 1958 to increase the amount that certain banks and savings associations may invest in small business investment companies, subject to the approval of the appropriate Federal banking agency, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

H.R. 2749. An act to amend title 38, United States Code, to improve the oversight of contracts awarded by the Secretary of Veterans Affairs to small business concerns owned and controlled by veterans, and for other purposes; to the Committee on Veterans' Affairs.

H.R. 2781. An act to direct the Secretary of Veterans Affairs to certify the sufficient participation of small business concerns owned and controlled by veterans and small business concerns owned by veterans with service-connected disabilities in contracts under the Federal Strategic Sourcing Initiative, and for other purposes; to the Committee on Veterans' Affairs.

## EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–2289. A communication from the Senior Official performing the duties of the Under Secretary of Defense (Acquisition, Technology and Logistics), transmitting, pursuant to law, a report entitled ''Fiscal Year 2016 Operational Energy Annual Report''; to the Committees on Appropriations; and Armed Services.

EC–2290. A communication from the Acting Assistant Secretary of Defense (Legislative Affairs), transmitting legislative proposals relative to the ''National Defense Authorization Act for Fiscal Year 2018''; to the Committee on Armed Services.

EC–2291. A communication from the General Counsel of the National Credit Union Administration, transmitting, pursuant to law, the report of a rule entitled ''Civil Monetary Penalty Inflation Adjustment'' (RIN3133–AE67) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Banking, Housing, and Urban Affairs.

EC–2292. A communication from the Secretary of Commerce, transmitting, pursuant to law, the annual report on the activities of the U.S. Economic Development Administration (EDA) for fiscal year 2016; to the Committee on Environment and Public Works.

EC–2293. A communication from the Director of Congressional Affairs, Office of General Counsel, Nuclear Regulatory Commission, transmitting, pursuant to law, the report of a rule entitled ''Revision of Fee Schedules; Fee Recovery for Fiscal Year 2017'' ((RIN3150–AJ73) (NRC–2016–0081)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Environment and Public Works.

EC–2294. A communication from the Acting Assistant Secretary for Legislation, Department of Health and Human Services, transmitting, pursuant to law, a report entitled ''Report to Congress on Ways to Improve Upon the Part D Appeal Process''; to the Committee on Finance.

EC–2295. A communication from the Bureau of Legislative Affairs, Department of State, transmitting, pursuant to section 36(c) of the Arms Export Control Act, the certification of a proposed license for the export of defense articles, including technical data, and defense services to Australia to support the P–8 Production, Sustainment, and Follow-on Development Memorandum of Understanding in the amount of $100,000,000 or more (Transmittal No. DDTC 17–042); to the Committee on Foreign Relations.

EC–2296. A communication from the Bureau of Legislative Affairs, Department of State, transmitting, pursuant to section 36(c) of the Arms Export Control Act, the certification of a proposed license for the export of firearms abroad controlled under Category I of the United States Munitions List of pistols to El Salvador in the amount of $1,000,000 or more (Transmittal No. DDTC 16–134); to the Committee on Foreign Relations.

EC–2297. A communication from the Deputy Assistant Secretary of Legislative Affairs, Department of the Treasury, transmitting, pursuant to law, a report to Congress from the Chairman of the National Advisory Council on International Monetary and Financial Policies; to the Committee on Foreign Relations.

EC–2298. A communication from the Chief Counsel, Foreign Claims Settlement Commission of the United States, Department of Justice, transmitting, pursuant to law, the Commission's annual report for 2016; to the Committee on Foreign Relations.

EC–2299. A communication from the Assistant General Counsel for Regulatory Services, Office of General Counsel, Department of Education, transmitting, pursuant to law, the report of a rule entitled ''Elementary and Secondary Education Act of 1965, as Amended by the Every Student Succeeds Act—Accountability and State Plans'' ((RIN1810–AB27) (Docket No. ED–2016–OESE–0032)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Health, Education, Labor, and Pensions.

EC–2300. A communication from the Chair, Advisory Council on Alzheimer's Research, Care, and Services, transmitting, pursuant to law, a report that includes recommendations for improving federally and privately funded Alzheimer's programs; to the Committee on Health, Education, Labor, and Pensions.

EC–2301. A communication from the Secretary of Education, transmitting, pursuant to law, the report of a rule entitled ''Teacher Preparations Issues'' (RIN1840–AD07) received in the Office of the President pro tempore of the Senate; to the Committee on Health, Education, Labor, and Pensions.

EC–2302. A communication from the Chief of the Border Security Branch, Customs and Border Protection, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Technical Amendments: Electronic Information for Cargo Exported from the United States'' (CBP Dec. 17–06) received in the Office of the President of the Senate on July 10, 2017; to the Committee on Homeland Security and Governmental Affairs.

EC–2303. A communication from the Acting Assistant Secretary of Defense (Legislative Affairs), transmitting legislative proposals relative to the ''National Defense Authorization Act for Fiscal Year 2018''; to the Committee on Homeland Security and Governmental Affairs.

EC–2304. A communication from the Director of Regulation Policy and Management, Department of Veterans Affairs, transmitting, pursuant to law, the report of a rule entitled ''VA Veteran-Owned Small Business Verification Guidelines'' (RIN2900–AP93) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Veterans' Affairs.

EC–2305. A joint communication from the Interim Deputy Secretary of Veterans Affairs and the Senior Official performing the duties of the Under Secretary of Defense (Personnel and Readiness), transmitting, pursuant to law, a report entitled ''Veterans Affairs and Department of Defense Joint Executive Committee Fiscal Year 2016 Annual Report''; to the Committee on Veterans' Affairs.

EC–2306. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Standard Instrument Approach Procedures, and Takeoff Minimums and Obstacle Departure Procedures; Miscellaneous Amendments (4); Amdt. No. 3750'' (RIN2120–AA65) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2307. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Standard Instrument Approach Procedures, and Takeoff Minimums and Obstacle Departure Procedures; Miscellaneous Amendments (76); Amdt. No. 3747'' (RIN2120–AA65) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2308. A communication from the Management and Program Analyst, Federal

Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Standard Instrument Approach Procedures, and Takeoff Minimums and Obstacle Departure Procedures; Miscellaneous Amendments (114); Amdt. No. 3749'' (RIN2120–AA65) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2309. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Standard Instrument Approach Procedures, and Takeoff Minimums and Obstacle Departure Procedures; Miscellaneous Amendments (129); Amdt. No. 3748'' (RIN2120–AA65) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2310. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2016–3984)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2311. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2016–9573)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2312. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2016–8185)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2313. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2016–0461)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2314. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2016–9071)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2315. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2016–9574)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2316. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2015–3148)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2317. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; The Boeing Company Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2016–9391)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2318. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; The Boeing Company Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2017–0126)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2319. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; The Boeing Company Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2016–9188)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2320. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; The Boeing Company Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2016–9502)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2321. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; The Boeing Company Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2016–9566)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2322. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; The Boeing Company Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2016–9384)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2323. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Bombardier, Inc. Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2017–0125)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2324. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Bombardier, Inc. Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2015–7529)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2325. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Bombardier, Inc. Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2017–0558)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2326. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Piper Aircraft, Inc. Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2016–9254)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2327. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Dassault Aviation Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2016–9504)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2328. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Gulfstream Aerospace Corporation Airplanes'' ((RIN2120–AA64) (Docket No. FAA–2016–9437)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2329. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Bell Helicopter Textron Canada Limited Helicopters'' ((RIN2120–AA64) (Docket No. FAA–2017–0078)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2330. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Helicopters Deutschland GmbH Helicopters'' ((RIN2120–AA64) (Docket No. FAA–2017–0061)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2331. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Helicopters'' ((RIN2120–AA64) (Docket No. FAA–2016–6693)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2332. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Helicopters'' ((RIN2120–AA64) (Docket No. FAA–2017–0060)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2333. A communication from the Management and Program Analyst, Federal

Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Rolls-Royce plc Turbofan Engines'' ((RIN2120–AA64) (Docket No. FAA–2017–0187)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2334. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; DG Flugzeugbau GmbH Gliders'' ((RIN2120–AA64) (Docket No. FAA–2017–0343)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2335. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Modification of VOR Federal Airways V–55, V–63, V–177, V–228, and V–246 in the Vicinity of Stevens Point, WI'' ((RIN2120–AA66) (Docket No. FAA–2016–9374)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2336. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of and Establishment of Air Traffic Service (ATS) Routes; Northcentral United States'' ((RIN2120–AA66) (Docket No. FAA–2016–8944)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2337. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class D and E Airspace; Tucson, AZ'' ((RIN2120–AA66) (Docket No. FAA–2017–0218)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2338. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class D and E Airspace for the following North Dakota Towns; Wahpeton, ND; Hettinger, ND; Fargo, ND; Grand Fork, ND; Carrington, ND; Cooperstown , ND; Pembina, ND; Rugby, ND; Devils Lake, ND; Bottineau, ND; Valley City, ND; and Gwinner, ND'' ((RIN2120–AA66) (Docket No. FAA–2016–9118)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2339. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class E Airspace; Hilo, HI'' ((RIN2120–AA66) (Docket No. FAA–2017–0222)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2340. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class E Airspace; Arcata, CA; Fortuna, CA; and Establishment of Class E Airspace; Arcata, CA, and Eureka, CA'' ((RIN2120–AA66) (Docket No. FAA–2015–6751)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2341. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Establishment of Class E Airspace; Finleyville, PA'' ((RIN2120–AA66) (Docket No. FAA–2016–9496)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2342. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Establishment of Class E Airspace; Grayling, AK'' ((RIN2120–AA66) (Docket No. FAA–2016–9333)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2343. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Establishment of Class E Airspace; Sacramento, CA'' ((RIN2120–AA66) (Docket No. FAA–2016–9476)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2344. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class E Airspace; Eugene, OR'' ((RIN2120–AA66) (Docket No. FAA–2017–0224)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2345. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Multiple Restricted Areas; Townsend, GA'' ((RIN2120–AA66) (FAA–2017–0585)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2346. A communication from the Management and Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Establishment of Temporary Restricted Areas R–2509E, R–2509W, and R–2509N; Twentynine Palms, CA'' ((RIN2120–AA66) (Docket No. FAA–2016–9536)) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2347. A communication from the Attorney-Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Drawbridge Operation Regulation; St. Louis River (Duluth-Superior Harbor), between the towns of Duluth, MN and Superior, WI'' ((RIN1625–AA09) (Docket No. USCG–2017–0212)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2348. A communication from the Attorney-Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Special Local Regulations; Safety Zones; Recurring Marine Events in Sector Columbia River'' ((RIN1625–AA08 and RIN1625–AA00) (Docket No. USCG–2017–0224)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2349. A communication from the Attorney-Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; Oswego Harborfest 2017 Breakwall and Barge Fireworks Display, Oswego Harbor, Oswego, NY'' ((RIN1625–AA00) (Docket No. USCG–2017–0359)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2350. A communication from the Attorney-Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; Lake Michigan, Whiting, Indiana'' ((RIN1625–AA00) (Docket No. USCG–2017–0195)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2351. A communication from the Attorney-Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; Port Huron Blue Water Fest Fireworks, St. Clair River, Port Huron, MI'' ((RIN1625–AA00) (Docket No. USCG–2017–0500)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2352. A communication from the Attorney-Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; Potomac River, Montgomery County, MD'' ((RIN1625–AA00) (Docket No. USCG–2017–0448)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2353. A communication from the Attorney-Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; Lakewood Independence Day Fireworks Display; Lake Erie, Lakewood, OH'' ((RIN1625–AA00) (Docket No. USCG–2017–0533)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2354. A communication from the Attorney-Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; Bay Village Independence Day Celebration Fireworks Display; Lake Erie, Bay Village, OH'' ((RIN1625–AA00) (Docket No. USCG–2017–0568)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2355. A communication from the Attorney-Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zones; Marine Events held in the Captain of the Port Long Island Sound Zone'' ((RIN1625–AA00) (Docket No. USCG–2017–0440)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2356. A communication from the Attorney-Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zones; Marine Events held in the Captain of the Port Long Island Sound Zone'' ((RIN1625–AA00) (Docket No. USCG–2017–0243)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2357. A communication from the Attorney-Advisor, U.S. Coast Guard, Department

of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; St. Ignace Fireworks Displays, St. Ignace, MI'' ((RIN1625–AA00) (Docket No. USCG–2017–0472)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2358. A communication from the Attorney-Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; Cleveland Triathlon Swim Event; Lake Erie, Cleveland, OH'' ((RIN1625–AA00) (Docket No. USCG–2017–0580)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2359. A communication from the Attorney-Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; Thunder on the Outer Harbor; Buffalo Outer Harbor, Buffalo, NY'' ((RIN1625–AA00) (Docket No. USCG–2017–0331)) received in the Office of the President of the Senate on July 13, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2360. A communication from the Vice President of Government Affairs and Corporate Communications, National Railroad Passenger Corporation, Amtrak, transmitting, pursuant to law, Amtrak's audited Consolidated Financial Statements for the years ended September 30, 2016 and September 30, 2015 with report of independent auditors; to the Committee on Commerce, Science, and Transportation.

EC–2361. A communication from the Deputy Assistant Chief Counsel, Federal Railroad Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Competitive Passenger Rail Service Pilot Program'' (RIN2130–AC60) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

EC–2362. A communication from the Acting Chairman of the Office of Proceedings, Surface Transportation Board, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Offers of Financial Assistance'' (RIN2140–AB27) received in the Office of the President of the Senate on July 19, 2017; to the Committee on Commerce, Science, and Transportation.

## PETITIONS AND MEMORIALS

The following petitions and memorials were laid before the Senate and were referred or ordered to lie on the table as indicated:

POM–76. A resolution adopted by the House of Representatives of the State of Michigan urging the United States Congress to continue full funding for the Facility for Rare Isotope Beams on the campus of Michigan State University; to the Committee on Commerce, Science, and Transportation.

HOUSE RESOLUTION NO. 113

Whereas, The President's proposed 2018 budget includes a $17 million cut in federal funding for the Facility for Rare Isotope Beams (FRIB) at Michigan State University. This could delay the project's anticipated completion date, increasing costs by an estimated $20 million; and

Whereas, Currently, the state-of-the-art project is on budget and ahead of schedule and is about three quarters completed. The FRIB will be the world's most powerful rare isotope beam facility upon completion; at least 1,000 times more powerful than Michigan State University's existing cyclotrons; and

Whereas, The FRIB will more than double the research opportunities available in the field of nuclear physics. Its cutting-edge discoveries will provide applications for society in such areas as cancer research, homeland security, and commercial innovation. A world class scientific facility such as the FRIB will address the U.S. innovation deficit and provide opportunities to train the next generation of scientific and business leaders; and

Whereas, The FRIB will have a huge impact on Michigan. It will contribute an estimated $4.4 billion in statewide economic activity over the course of its lifespan. It is expected to create over 1,000 jobs, generate wages of $1.7 billion, and strengthen and diversify the state's economy through investments in research and innovation; and

Whereas, It is critically important that federal funding continue to provide a solid foundation for cutting-edge scientific research at the FRIB. A funding shortfall and delay could mean canceled contracts and missed opportunities in the region's burgeoning particle science industry. Continuation of full funding is essential to keeping FRIB construction on time and on budget; now, therefore, be it

Resolved by the House of Representatives, That we urge the United States Congress to continue full funding for the Facility for Rare Isotope Beams on the campus of Michigan State University; and be it further

Resolved, That copies of this resolution be transmitted to the President of the United States, the President of the United States Senate the Speaker of the United States House of Representatives, and the members of the Michigan congressional delegation.

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POM–77. A joint resolution adopted by the Legislature of the State of Alaska making application to the United States Congress to call a convention of the state to propose a countermand amendment to the United States Constitution as provided under Article V; and urging the legislatures of the other 49 states to make the same application; to the Committee on the Judiciary.

HOUSE JOINT RESOLUTION NO. 14

Whereas the state's sovereignty has been infringed upon by the federal government, including by the federal government's recent denial of and refusal to work with state officials on the construction of a lifesaving road from King Cove to Cold Bay; and

Whereas the state's access to a fair permitting process for projects that will develop the state's natural resources and provide revenue streams to the state, including oil exploration in the Arctic National Wildlife Refuge and large-scale mining projects throughout the state, has been continually denied by the United States Environmental Protection Agency and other agencies of the federal government; and

Whereas the United States Congress has, at times, exceeded its delegated powers, the President of the United States has, at times, exceeded the constitutional authority of the office of the President of the United States, and the federal courts have, at times, exceeded their authority by issuing decisions on public policy matters reserved to the states in violation of the principles of federalism and separation of powers, all of which have adversely affected the state and its people; and

Whereas, under the authority of art. V, Constitution of the United States, the several states should apply to the United States Congress to call a convention of the states to amend the United States Constitution and adopt a countermand amendment to authorize the states, upon a vote of three-fifths of the state legislatures, to nullify and repeal a federal statute, executive order, judicial decision, regulatory decision by a federal government agency, or government mandate imposed on the states by law that adversely affects the interests of the states, in order to properly exercise the states' constitutional authority to check federal power, preserve state sovereignty, and protect the rights of the states and the people; and

Whereas the states have the authority to define and limit the agenda of a convention to a single-issue ''countermand amendment convention'' called for by the states as provided under art. V, Constitution of the United States; and

Whereas the delegates sent by the states to a countermand amendment convention shall have the limited authority to deliberate on and decide whether the countermand amendment, as preapproved by state legislatures, should be sent back to the state legislatures for ratification; Be it

*Resolved,* That, under art. V, Constitution of the United States, the Alaska State Legislature directs the United States Congress to call. a single-issue convention of the states, called a ''countermand amendment convention,'' for the sole purpose of deciding whether the proposed countermand amendment should be sent back to the state legislatures for ratification; and be it further

*Resolved,* That the Alaska State Legislature directs the United States Congress to convene the countermand amendment convention within 60 days after the date it receives the 34th call for that convention from state legislatures; and be it further

*Resolved,* That this application constitutes a continuing application in accordance with art. V, Constitution of the United States, until at least two-thirds of the legislatures of the several states have applied for a similar convention of the states; and be it further

*Resolved,* That the Alaska State Legislature urges the legislatures of the other 49 states to apply to the United States Congress to call a single-issue countermand convention of the states under art. V, Constitution of the United States.

Copies of this resolution shall be sent to the Honorable Barack Obama, President of the United States; the Honorable Joseph R. Biden, Jr., Vice-President of the United States and President of the U.S. Senate; the Honorable John Boehner, Speaker of the U.S. House of Representatives; the Honorable Mitch McConnell, Majority Leader of the U.S. Senate; the Honorable Nancy Erickson, Secretary of the U.S. Senate; the Honorable Karen L. Haas, Clerk of the U.S. House of Representatives; the Honorable Lisa Murkowski and the Honorable Dan Sullivan, U.S. Senators, and the Honorable Don Young, U.S. Representative, members of the Alaska delegation in Congress; and the presiding officers of the legislatures of each of the other 49 states.

## EXECUTIVE REPORTS OF COMMITTEE

The following executive reports of nominations were submitted:

By Mr. BURR for the Select Committee on Intelligence.

Robert P. Storch, of the District of Columbia, to be Inspector General of the National Security Agency.

*Isabel Marie Keenan Patelunas, of Pennsylvania, to be Assistant Secretary for Intelligence and Analysis, Department of the Treasury.

*Susan M. Gordon, of Virginia, to be Principal Deputy Director of National Intelligence.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

(Nominations without an asterisk were reported with the recommendation that they be confirmed.)

## INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. UDALL (for himself, Mr. BLUMENTHAL, Mr. BOOKER, Mr. DURBIN, Mrs. GILLIBRAND, Mr. MARKEY, Ms. HARRIS, Mr. CARDIN, and Mr. MERKLEY):

S. 1624. A bill to prohibit the use of chlorpyrifos on food, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. BLUMENTHAL:

S. 1625. A bill for the relief of Nury Chavarria; to the Committee on the Judiciary.

By Mr. BLUMENTHAL (for himself, Mrs. FEINSTEIN, and Mr. MARKEY):

S. 1626. A bill to improve the safety of the air supply on commercial aircraft, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mrs. GILLIBRAND (for herself, Mr. BLUMENTHAL, Mr. MURPHY, and Mr. CASEY):

S. 1627. A bill to extend the authorization of the Highlands Conservation Act; to the Committee on Energy and Natural Resources.

By Mr. GRASSLEY (for himself, Mrs. ERNST, and Mr. FRANKEN):

S. 1628. A bill to revise counseling requirements for certain borrowers of student loans, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. REED (for himself, Mr. ROUNDS, Mr. BROWN, Ms. COLLINS, Mr. CARPER, Mr. COONS, Mr. WHITEHOUSE, Mrs. SHAHEEN, Ms. CORTEZ MASTO, and Ms. HIRONO):

S. 1629. A bill to reauthorize the Department of Defense Experimental Program to Stimulate Competitive Research, and for other purposes; to the Committee on Armed Services.

By Mr. CASEY (for himself, Ms. BALDWIN, and Mr. BROWN):

S. 1630. A bill to establish in the Administration for Children and Families of the Department of Health and Human Services the Federal Interagency Working Group on Reducing Child Poverty to develop a national strategy to eliminate child poverty in the United States, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. CORKER:

S. 1631. A bill to authorize the Department of State for Fiscal Year 2018, and for other purposes; to the Committee on Foreign Relations.

## SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. GRASSLEY (for himself, Mr. JOHNSON, Ms. BALDWIN, Mr. CARPER, Mr. WYDEN, Mr. MARKEY, Mr. BOOZMAN, Mrs. MCCASKILL, Mr. TILLIS, Mrs. ERNST, Mrs. FISCHER, Mr. PETERS, and Mrs. FEINSTEIN):

S. Res. 231. A resolution designating July 30, 2017, as ''National Whistleblower Appreciation Day''; to the Committee on the Judiciary.

## ADDITIONAL COSPONSORS

S. 170

At the request of Mr. RUBIO, the names of the Senator from Colorado (Mr. GARDNER) and the Senator from Massachusetts (Mr. MARKEY) were added as cosponsors of S. 170, a bill to provide for nonpreemption of measures by State and local governments to divest from entities that engage in commerce-related or investment-related boycott, divestment, or sanctions activities targeting Israel, and for other purposes.

S. 259

At the request of Mr. NELSON, the name of the Senator from North Carolina (Mr. BURR) was added as a cosponsor of S. 259, a bill to modify the prohibition on recognition by United States courts of certain rights relating to certain marks, trade names, or commercial names.

S. 266

At the request of Mr. HATCH, the name of the Senator from South Dakota (Mr. ROUNDS) was added as a cosponsor of S. 266, a bill to award the Congressional Gold Medal to Anwar Sadat in recognition of his heroic achievements and courageous contributions to peace in the Middle East.

S. 372

At the request of Mr. PORTMAN, the name of the Senator from Virginia (Mr. KAINE) was added as a cosponsor of S. 372, a bill to amend the Tariff Act of 1930 to ensure that merchandise arriving through the mail shall be subject to review by U.S. Customs and Border Protection and to require the provision of advance electronic information on shipments of mail to U.S. Customs and Border Protection and for other purposes.

S. 407

At the request of Mr. CRAPO, the name of the Senator from Maryland (Mr. VAN HOLLEN) was added as a cosponsor of S. 407, a bill to amend the Internal Revenue Code of 1986 to permanently extend the railroad track maintenance credit.

S. 445

At the request of Mr. CARDIN, the name of the Senator from New Jersey (Mr. BOOKER) was added as a cosponsor of S. 445, a bill to amend title XVIII of the Social Security Act to ensure more timely access to home health services for Medicare beneficiaries under the Medicare program.

S. 448

At the request of Mr. BROWN, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 448, a bill to amend title XVIII of the Social Security Act to provide for treatment of clinical psychologists as physicians for purposes of furnishing clinical psychologist services under the Medicare program.

S. 474

At the request of Mr. GRAHAM, the name of the Senator from Texas (Mr. CORNYN) was added as a cosponsor of S. 474, a bill to condition assistance to the West Bank and Gaza on steps by the Palestinian Authority to end violence and terrorism against Israeli citizens.

S. 602

At the request of Ms. COLLINS, the names of the Senator from Michigan (Mr. PETERS) and the Senator from South Carolina (Mr. GRAHAM) were added as cosponsors of S. 602, a bill to amend the Internal Revenue Code of 1986 to include automated fire sprinkler system retrofits as section 179 property and classify certain automated fire sprinkler system retrofits as 15-year property for purposes of depreciation.

S. 654

At the request of Mr. TOOMEY, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 654, a bill to revise section 48 of title 18, United States Code, and for other purposes.

S. 720

At the request of Mr. PORTMAN, the name of the Senator from Louisiana (Mr. KENNEDY) was added as a cosponsor of S. 720, a bill to amend the Export Administration Act of 1979 to include in the prohibitions on boycotts against allies of the United States boycotts fostered by international governmental organizations against Israel and to direct the Export-Import Bank of the United States to oppose boycotts against Israel, and for other purposes.

S. 822

At the request of Mr. INHOFE, the name of the Senator from Massachusetts (Ms. WARREN) was added as a cosponsor of S. 822, a bill to amend the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 to modify provisions relating to grants, and for other purposes.

S. 1002

At the request of Mr. MORAN, the name of the Senator from Nebraska (Mrs. FISCHER) was added as a cosponsor of S. 1002, a bill to enhance the ability of community financial institutions to foster economic growth and serve their communities, boost small businesses, increase individual savings, and for other purposes.

S. 1018

At the request of Mr. CARDIN, the name of the Senator from North Carolina (Mr. TILLIS) was added as a cosponsor of S. 1018, a bill to provide humanitarian assistance for the Venezuelan people, to defend democratic governance and combat widespread public corruption in Venezuela, and for other purposes.

S. 1146

At the request of Mrs. SHAHEEN, the name of the Senator from Michigan

(Ms. STABENOW) was added as a cosponsor of S. 1146, a bill to enhance the ability of the Office of the National Ombudsman to assist small businesses in meeting regulatory requirements and develop outreach initiatives to promote awareness of the services the Office of the National Ombudsman provides, and for other purposes.

S. 1182

At the request of Ms. CANTWELL, her name was added as a cosponsor of S. 1182, a bill to require the Secretary of the Treasury to mint commemorative coins in recognition of the 100th anniversary of The American Legion.

S. 1199

At the request of Mrs. MCCASKILL, the names of the Senator from Montana (Mr. TESTER) and the Senator from Wisconsin (Mr. JOHNSON) were added as cosponsors of S. 1199, a bill to amend the Homeland Security Act of 2002 to reauthorize the Border Enforcement Security Task Force program within the Department of Homeland Security, and for other purposes.

S. 1251

At the request of Mr. WARNER, the name of the Senator from Indiana (Mr. YOUNG) was added as a cosponsor of S. 1251, a bill to require the Secretary of Labor to establish a pilot program for providing portable benefits to eligible workers, and for other purposes.

S. 1286

At the request of Ms. KLOBUCHAR, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 1286, a bill to lift the trade embargo on Cuba.

S. 1290

At the request of Mr. LEE, the names of the Senator from Georgia (Mr. PERDUE) and the Senator from Oklahoma (Mr. INHOFE) were added as cosponsors of S. 1290, a bill to help individuals receiving assistance under means-tested welfare programs obtain self-sufficiency, to provide information on total spending on means-tested welfare programs, to provide an overall spending limit on means-tested welfare programs, and for other purposes.

S. 1331

At the request of Ms. STABENOW, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 1331, a bill to establish the Great Lakes Mass Marking Program, and for other purposes.

S. 1332

At the request of Ms. STABENOW, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 1332, a bill to establish the Great Lakes Aquatic Connectivity and Infrastructure Program, and for other purposes.

S. 1398

At the request of Ms. STABENOW, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 1398, a bill to direct the Secretary of the Army, acting through the Chief of Engineers, to release an interim report related to aquatic nuisance species control, and for other purposes.

S. 1462

At the request of Mrs. SHAHEEN, the name of the Senator from New Mexico (Mr. HEINRICH) was added as a cosponsor of S. 1462, a bill to amend the Patient Protection and Affordable Care Act to improve cost sharing subsidies.

S. 1480

At the request of Mr. KING, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of S. 1480, a bill to amend the Internal Revenue Code of 1986 to include biomass heating appliances for tax credits available for energy-efficient building property and energy property.

S. 1575

At the request of Mr. WHITEHOUSE, the name of the Senator from New Hampshire (Ms. HASSAN) was added as a cosponsor of S. 1575, a bill to amend the Internal Revenue Code of 1986 to provide a tax credit for taxpayers who remove lead-based hazards.

S. 1585

At the request of Mr. WHITEHOUSE, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 1585, a bill to amend the Federal Election Campaign Act of 1971 to provide for additional disclosure requirements for corporations, labor organizations, Super PACs and other entities, and for other purposes.

S. 1598

At the request of Mr. TESTER, the names of the Senator from New York (Mrs. GILLIBRAND), the Senator from New Jersey (Mr. MENENDEZ) and the Senator from Virginia (Mr. WARNER) were added as cosponsors of S. 1598, a bill to amend title 38, United States Code, to make certain improvements in the laws administered by the Secretary of Veterans Affairs, and for other purposes.

At the request of Mr. ISAKSON, the name of the Senator from Iowa (Mr. GRASSLEY) was added as a cosponsor of S. 1598, supra.

S. 1600

At the request of Ms. HIRONO, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 1600, a bill to amend title II of the Social Security Act and the Internal Revenue Code of 1986 to make improvements in the old-age, survivors, and disability insurance program, and to provide for Social Security benefit protection.

S. 1619

At the request of Mr. DURBIN, the name of the Senator from Connecticut (Mr. BLUMENTHAL) was added as a cosponsor of S. 1619, a bill to amend the Servicemembers Civil Relief Act to extend the interest rate limitation on debt entered into during military service to debt incurred during military service to consolidate or refinance student loans incurred before military service.

S. 1620

At the request of Mr. COTTON, the name of the Senator from Florida (Mr. RUBIO) was added as a cosponsor of S. 1620, a bill to enhance the security of Taiwan and bolster its participation in the international community, and for other purposes.

## STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. UDALL (for himself, Mr. BLUMENTHAL, Mr. BOOKER, Mr. DURBIN, Mrs. GILLIBRAND, Mr. MARKEY, Ms. HARRIS, Mr. CARDIN, and Mr. MERKLEY):

S. 1624. A bill to prohibit the use of chlorpyrifos on food, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. UDALL. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1624

*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 ''Protect Children, Farmers, and Farmworkers from Nerve Agent Pesticides Act of 2017''.

**SEC. 2. FINDINGS.**

Congress finds as follows:

(1) In 1996, Congress unanimously passed the Food Quality Protection Act of 1996 (Public Law 104–170; 110 Stat. 1489) (referred to in this section as ''FQPA''), a comprehensive overhaul of Federal pesticide and food safety policy. That Act amended the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136 et seq.) (referred to in this section as ''FIFRA'') and the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.), the laws that govern how the Environmental Protection Agency (referred to in this section as the ''EPA'') registers pesticides and pesticide labels for use in the United States and establishes tolerances or acceptable levels for pesticide residues on food.

(2) The FQPA directs the EPA to ensure with ''reasonable certainty'' that ''no harm'' will result from food, drinking water, and other exposures to a pesticide. If EPA cannot make this safety finding, it must prohibit residues and use of the pesticide on food. The FQPA mandates that EPA must consider children's special sensitivity and exposure to pesticide chemicals and must make an explicit determination that the pesticide can be used with a ''reasonable certainty of no harm'' to children. In determining acceptable levels of pesticide residue, EPA must account for the potential health harm from pre-and postnatal exposures. The economic benefits of pesticides cannot be used to override this health-based standard for children from food and other exposures.

(3) Chlorpyrifos is a widely used pesticide first registered by EPA in 1965. Chlorpyrifos is an organophosphate pesticide, a class of pesticides developed as nerve agents in World War II and adapted for use as insecticides after the war. Chlorpyrifos and other organophosphate pesticides affect the nervous system through inhibition of cholinesterase, an enzyme required for proper nerve functioning. Acute poisonings occur when nerve impulses pulsate through the

body, causing symptoms like nausea, vomiting, convulsions, respiratory paralysis, and, in extreme cases, death. Based on dozens of peer-reviewed scientific articles, EPA determined that exposure during pregnancy to even low levels of chlorpyrifos that caused only minimal cholinesterase inhibition (10 percent or less) in the mothers could lead to measurable long-lasting and possibly permanent neurobehavioral and functional deficits in prenatally exposed children.

(4) People, including pregnant women, are exposed to chlorpyrifos through residues on food, contaminated drinking water, and toxic spray drift from nearby pesticide applications. Chlorpyrifos is used on an extensive variety of crops, including fruit and nut trees, vegetables, wheat, alfalfa, and corn. Between 2006 and 2012, chlorpyrifos was applied to more than 50 percent of the Nation's apple and broccoli crops, 45 percent of onion crops, 46 percent of walnut crops, and 41 percent of cauliflower crops.

(5) Chlorpyrifos is acutely toxic and associated with neurodevelopmental harms in children. Prenatal exposure to chlorpyrifos is associated with elevated risks of reduced IQ, loss of working memory, delays in motor development, attention-deficit disorders, and structural changes in the brain.

(6) There is no nationwide chlorpyrifos use reporting. The United States Geological Survey estimates annual pesticide use on agricultural land in the United States, and estimates that chlorpyrifos use on crops in 2014 ranged from 5,000,000 to 7,000,000 pounds of chlorpyrifos.

(7) In its 2016 report, the Federal Insecticide, Fungicide, and Rodenticide Act Scientific Advisory Panel recognized ''the growing body of literature with laboratory animals (rats and mice) indicating that gestational and/or early postnatal exposure to chlorpyrifos may cause persistent effects into adulthood along with epidemiology studies which have evaluated prenatal chlorpyrifos exposure in mother-infant pairs and reported associations with neurodevelopment outcomes in infants and children.''.

(8) Chlorpyrifos has long been of concern to EPA. Residential uses of chlorpyrifos ended in 2000 after EPA found unsafe exposures to children. EPA also discontinued use of chlorpyrifos on tomatoes and restricted its use on apples and grapes in 2000, and obtained no-spray buffers around schools, homes, playfields, day cares, hospitals, and other public places, ranging from 10 to 100 feet. In 2015, EPA proposed to ban all chlorpyrifos food tolerances, based on unsafe drinking water contamination, which would end use of chlorpyrifos on food in the United States. After updating the risk assessment for chlorpyrifos in November 2016 to protect against prenatal exposures associated with brain impacts, EPA found that expected residues from use on food crops exceeded the safety standard, and additionally the majority of estimated drinking water exposures from currently allowed uses of chlorpyrifos also exceeded acceptable levels, reinforcing the need to revoke all food tolerances for the pesticide.

(9) Chlorpyrifos threatens the healthy development of children. Children experience greater exposure to chlorpyrifos and other pesticides because, relative to adults, they eat and drink more proportional to their body weight. A growing body of evidence shows that prenatal exposure to very low levels of chlorpyrifos can lead to lasting and possibly permanent neurological impairments. In November 2016, EPA released a revised human health risk assessment for chlorpyrifos that confirmed that there are no acceptable uses for the pesticide, all food uses exceed acceptable levels, with children ages 1 to 2 exposed to levels of chlorpyrifos that are 140 times what the EPA considers acceptable.

(10) Chlorpyrifos threatens agricultural workers. Farm workers are exposed to chlorpyrifos from mixing, handling, and applying the pesticide, as well as from entering fields where chlorpyrifos was recently sprayed. Chlorpyrifos is one of the pesticides most often linked to acute pesticide poisonings, and in many States, it is regularly identified among the 5 pesticides linked to the highest number of pesticide poisoning incidents. This is significant given widespread under-reporting of pesticide poisonings due to such factors as inadequate reporting systems, fear of retaliation from employers, and reluctance to seek medical treatment. According to the EPA, all workers who mix and apply chlorpyrifos are exposed to unsafe levels of the pesticide even with maximum personal protective equipment and engineering controls. Field workers are currently allowed to re-enter fields within 1 to 5 days after chlorpyrifos is sprayed based on current restricted entry intervals on the registered chlorpyrifos labels but unsafe exposures continue on average 18 days after applications.

(11) Chlorpyrifos threatens families in agricultural communities. Rural families are exposed to unsafe levels of chlorpyrifos on their food and in their drinking water. They are also exposed to toxic levels of chlorpyrifos when it drifts from the fields to homes, schools, and other places people gather. EPA's 2016 revised human health risk assessment found that chlorpyrifos drift reaches unsafe levels at 300 feet away from the edge of the treated field, and the chemical chlorpyrifos is found at unsafe levels in the air at schools, homes, and communities in agricultural areas. The small buffers put in place in 2012 leave children unprotected from this toxic pesticide drift.

(12) Chlorpyrifos threatens drinking water. EPA's 2014 and 2016 risk assessments have found that chlorpyrifos levels in drinking water are unsafe. People living and working in agricultural communities are likely to be exposed to higher levels of chlorpyrifos and other organophosphate pesticides in their drinking water.

(13) In 2015, leading scientific and medical experts, along with children's health advocates, came together, under ''Project TENDR: Targeting Environmental Neuro-Developmental Risks'' (referred to in this section as ''TENDR''), to issue a call to action to reduce widespread exposures to chemicals that interfere with fetal and children's brain development. Based on the available and peer-reviewed scientific evidence, the TENDR authors identified prime examples of neurodevelopmentally toxic chemicals ''that can contribute to learning, behavioral, or intellectual impairment, as well as specific neurodevelopmental disorders such as ADHD or autism spectrum disorder,'' and listed organophosphate pesticides, among them. In the United States, based on reporting from parents, 1 in 6 children have a developmental disability or other developmental delay. The TENDR Consensus Statement concludes that ''to help reduce the unacceptably high prevalence of neurodevelopmental disorders in our children, we must eliminate or significantly reduce exposures to chemicals that contribute to these conditions.''.

**SEC. 3. PROHIBITIONS RELATING TO CHLORPYRIFOS.**

Section 402 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 342) is amended by adding at the end the following:

''(j) Notwithstanding any other provision of law, if it bears or contains chlorpyrifos, including any residue of chlorpyrifos, or any other added substance that is present on or in the food primarily as a result of the metabolism or other degradation of chlorpyrifos.''.

**SEC. 4. REVIEW OF ORGANOPHOSPHATE PESTICIDES.**

(a) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Administrator of the Environmental Protection Agency (referred to in this section as the ''Administrator'') shall offer to enter into a contract with the National Research Council to conduct a cumulative and aggregate risk assessment that addresses all populations, and the most vulnerable subpopulations, including infants, children, and fetuses, of exposure to organophosphate pesticides.

(b) CONTENTS OF REVIEW.—The review under subsection (a) shall—

(1) assess the neurodevelopmental effects and other low-dose effects of exposure to organophosphate pesticides, including in the most vulnerable subpopulations, including—

(A) during the prenatal, childhood, adolescent, and early life stages; and

(B) agricultural workers;

(2) assess the cumulative and aggregate risks from exposure described in paragraph (1), which shall aggregate all routes of exposure, including diet, pesticide drift, volatilization, occupational, and take-home exposures; and

(3) be completed and submitted to the Administrator not later than October 1, 2019.

(c) REGULATORY ACTION.—

(1) APPLICABILITY.—This subsection shall apply if the Administrator becomes aware of any exposure to any organophosphate pesticide, including exposures described in paragraphs (1) and (2) of subsection (b), that does not meet, as applicable—

(A) the standard under section 408(b)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 346a(b)(2)); or

(B) any standard under the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136 et seq.).

(2) ACTION.—Not later than 90 days after the date on which the Administrator becomes aware of any exposure under paragraph (1), the Administrator shall take any appropriate regulatory action, regardless of whether the review under subsection (a) is completed, including—

(A) revocation or modification of a tolerance under section 408 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 346a); or

(B) modification, cancellation, or suspension of a registration under the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136 et seq.).

(d) EFFECT.—Nothing in this section authorizes or requires the Administrator to delay in carrying out or completing, with respect to an organophosphate pesticide, any registration review under section 3(g) of the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136a(g)), any tolerance review under section 408 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 346a), or any registration or modification, cancellation, or suspension of a registration under section 3 or 6 of the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136a, 136d), if—

(1) the organophosphate pesticide does not meet applicable requirements established under those provisions of law; or

(2) the review, registration, modification, cancellation, or suspension is required—

(A) by statute;

(B) by judicial order; or

(C) to respond to a petition.

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By Mr. REED (for himself, Mr. ROUNDS, Mr. BROWN, Ms. COLLINS, Mr. CARPER, Mr. COONS,

Mr. WHITEHOUSE, Mrs. SHAHEEN, Ms. CORTEZ MASTO, and Ms. HIRONO):

S. 1629. A bill to reauthorize the Department of Defense Experimental Program to Stimulate Competitive Research, and for other purposes; to the Committee on Armed Services.

Mr. REED. Mr. President, today I am introducing the DEPSCoR Reauthorization Act of 2017 along with Senators ROUNDS, BROWN, COLLINS, CARPER, COONS, WHITEHOUSE, SHAHEEN, CORTEZ MASTO, and HIRONO.

The purpose of this bill is to ensure that we have universities in all 50 States capable of working with the Department of Defense on advanced research topics. A truly National network of university researchers who understand the needs of the Department of Defense puts us in the best possible position to respond to the ever-changing threats our armed forces face. This network will also meet the workforce needs of our defense laboratories by training graduate students in defense-relevant research. This bill reauthorizes the DEPSCoR program, which is modeled on the NSF's successful EPSCoR program for States that receive relatively low amounts of Federal science funding. The bill will focus the DEPSCoR program on defense research, while allowing the scientists and engineers of our defense laboratories to work directly with university researchers from DEPSCoR-eligible States.

Seven years ago, Congress asked the National Academy of Sciences to study the EPSCoR programs. The study concluded that it was in the National interest to engage scientific talent in all 50 States, and that EPSCoR programs were a valuable part of a National strategy to maintain global scientific leadership. The report emphasized that successfully engaging all 50 States required the involvement of technology-driven agencies, including the Department of Defense, to complement the basic science focus of the NSF.

Until 2009, the Department of Defense managed an EPSCoR-like program, known as DEPSCoR. An independent evaluation of DEPSCoR, conducted by the Institute for Defense Analyses, showed that DEPSCoR research contributed to the DoD mission, producing high-quality research and new technologies that were operationally deployed in areas such as missile guidance and communications.

DEPSCoR also successfully developed defense research capabilities in States historically underserved by Federal research and development (R&D) funding. Since DEPSCoR stopped receiving Congressional support, defense research in DEPSCoR-eligible States has plummeted, with the decreases far larger than the relatively modest amounts going to DEPSCoR awards. This shows that DEPSCoR was doing what Congress intended the program to do: develop competitive defense researchers in all 50 States.

The impact of cancelling DEPSCoR went far beyond research grants. Developing university research capabilities in all 50 States is critical to meeting DoD workforce needs. The Defense Laboratory Enterprise is more national in scope than NASA or the Department of Energy's National Laboratory system, with facilities in 24 States, including DEPSCoR-eligible States. The 2016 review of DoD laboratories by the Defense Science Board reported that these laboratories depend on locally trained scientists and engineers. Without relevant training provided through DoD-supported research projects at nearby universities, these facilities may struggle to find highly qualified scientists and engineers.

Because of these concerns, I have been working with my colleague on the Armed Services Committee, Senator ROUNDS of South Dakota, to revive this program. This reauthorization uses the lessons learned from the previous iteration of DEPSCoR to improve the program, making it more responsive to Department of Defense needs.

I invite our colleagues to join us in supporting this legislation.

## SUBMITTED RESOLUTIONS

### SENATE RESOLUTION 231—DESIGNATING JULY 30, 2017, AS ''NATIONAL WHISTLEBLOWER APPRECIATION DAY''

Mr. GRASSLEY (for himself, Mr. JOHNSON, Ms. BALDWIN, Mr. CARPER, Mr. WYDEN, Mr. MARKEY, Mr. BOOZMAN, Mrs. MCCASKILL, Mr. TILLIS, Mrs. ERNST, Mrs. FISCHER, Mr. PETERS, and Mrs. FEINSTEIN) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 231

Whereas, in 1777, before the passage of the Bill of Rights, 10 sailors and marines blew the whistle on fraud and misconduct that was harmful to the United States;

Whereas the Founding Fathers unanimously supported the whistleblowers in words and deeds, including by releasing government records and providing monetary assistance for the reasonable legal expenses necessary to prevent retaliation against the whistleblowers;

Whereas, on July 30, 1778, in demonstration of their full support for whistleblowers, the members of the Continental Congress unanimously enacted the first whistleblower legislation in the United States that read: ''*Resolved*, That it is the duty of all persons in the service of the United States, as well as all other the inhabitants thereof, to give the earliest information to Congress or other proper authority of any misconduct, frauds or misdemeanors committed by any officers or persons in the service of these states, which may come to their knowledge'' (legislation of July 30, 1778, reprinted in *Journals of the Continental Congress, 1774–1789*, ed. Worthington C. Ford et al. (Washington, D.C., 1904–37), 11:732);

Whereas whistleblowers risk their careers, jobs, and reputations by reporting waste, fraud, and abuse to the proper authorities;

Whereas, in providing the proper authorities with lawful disclosures, whistleblowers save the taxpayers of the United States billions of dollars each year and serve the public interest by ensuring that the United States remains an ethical and safe place; and

Whereas it is the public policy of the United States to encourage, in accordance with Federal law (including the Constitution of the United States, rules, and regulations) and consistent with the protection of classified information (including sources and methods of detection of classified information), honest and good faith reporting of misconduct, fraud, misdemeanors, and other crimes to the appropriate authority at the earliest time possible: Now, therefore, be it

*Resolved*, That the Senate—

(1) designates July 30, 2017, as ''National Whistleblower Appreciation Day''; and

(2) ensures that the Federal Government implements the intent of the Founding Fathers, as reflected in the legislation enacted on July 30, 1778, by encouraging each executive agency to recognize National Whistleblower Appreciation Day by—

(A) informing employees, contractors working on behalf of United States taxpayers, and members of the public about the legal right of a United States citizen to ''blow the whistle'' to the appropriate authority by honest and good faith reporting of misconduct, fraud, misdemeanors, or other crimes; and

(B) acknowledging the contributions of whistleblowers to combating waste, fraud, abuse, and violations of laws and regulations of the United States.

## AMENDMENTS SUBMITTED AND PROPOSED

SA 262. Mrs. SHAHEEN (for herself and Mr. SASSE) submitted an amendment intended to be proposed by her to the bill S. 1519, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table.

SA 263. Mrs. SHAHEEN submitted an amendment intended to be proposed by her to the bill S. 1519, supra; which was ordered to lie on the table.

SA 264. Mr. MCCAIN submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table.

SA 265. Mr. MCCAIN submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 266. Mr. MCCAIN submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 267. Mr. MCCONNELL proposed an amendment to the bill H.R. 1628, supra.

SA 268. Mr. WHITEHOUSE submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 269. Mr. REED (for himself, Mr. ROUNDS, Mr. BROWN, Ms. COLLINS, Mr. CARPER, Mr. COONS, Mr. WHITEHOUSE, Mrs. SHAHEEN, Ms. CORTEZ MASTO, and Ms. HIRONO) submitted an amendment intended to be proposed by him to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table.

SA 270. Mr. McCONNELL proposed an amendment to amendment SA 267 proposed by Mr. McCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017.

SA 271. Mr. ENZI (for Mr. PAUL) proposed an amendment to amendment SA 267 proposed by Mr. McCONNELL to the bill H.R. 1628, supra.

SA 272. Mr. JOHNSON submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. McCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 273. Mr. JOHNSON submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. McCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 274. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. McCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 275. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. McCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 276. Mr. KAINE (for himself, Mr. CARPER, Mr. COONS, Mrs. SHAHEEN, Mr. CARDIN, Ms. HASSAN, Ms . KLOBUCHAR, Ms. STABENOW, Mr. WARNER, Ms. HEITKAMP, and Mr. NELSON) submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 277. Mr. KAINE submitted an amendment intended to be proposed by him to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table.

SA 278. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 279. Mr. PAUL submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table.

SA 280. Mr. PAUL submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

## TEXT OF AMENDMENTS

**SA 262.** Mrs. SHAHEEN (for herself and Mr. SASSE) submitted an amendment intended to be proposed by her to the bill S. 1519, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title XII, add the following:

**SEC. 1235. SYRIA STUDY GROUP.**

(a) ESTABLISHMENT.—There is hereby established a working group to be known as the ''Syria Study Group'' (in this section referred to as the ''Group'').

(b) PURPOSE.—The purpose of the Group is to examine and make recommendations with respect to the military and diplomatic strategy of the United States with respect to the conflict in Syria.

(c) COMPOSITION.—

(1) MEMBERSHIP.—The Group shall be composed of 8 members appointed as follows:

(A) One member appointed by the chair of the Committee on Armed Services of the Senate.

(B) One member appointed by the ranking minority member of the Committee on Armed Services of the Senate.

(C) One member appointed by the chair of the Committee on Foreign Relations of the Senate.

(D) One member appointed by the ranking minority member of the Committee on Foreign Relations of the Senate.

(E) One member appointed by the chair of the Committee on Armed Services of the House of Representatives.

(F) One member appointed by the ranking minority member of the Committee on Armed Services of the House of Representatives.

(G) One member appointed by the chair of the Committee on Foreign Affairs of the House of Representatives.

(H) One member appointed by the ranking minority member of the Committee on Foreign Affairs of the House of Representatives.

(2) CO-CHAIRS.—

(A) The chair of the Committee on Armed Services of the Senate, the chair of the Committee on Armed Services of the House of Representatives, the chair of the Committee on Foreign Relations of the Senate, and the chair of the Committee on Foreign Affairs of the House of Representatives shall jointly designate one member of the Group to serve as co-chair of the Group.

(B) The ranking minority member of the Committee on Armed Services of the Senate, the ranking minority member of the Committee on Armed Services of the House of Representatives, the ranking minority member of the Committee on Foreign Relations of the Senate, and the ranking minority member of the Committee on Foreign Affairs of the House of Representatives shall jointly designate one member of the Group to serve as co-chair of the Group.

(3) PERIOD OF APPOINTMENT; VACANCIES.—Members shall be appointed for the life of the Group. Any vacancy in the Group shall be filled in the same manner as the original appointment.

(d) DUTIES.—

(1) REVIEW.—The Group shall review the current situation with respect to the United States military and diplomatic strategy in Syria, including a review of current United States objectives in Syria and the desired end state in Syria.

(2) ASSESSMENT AND RECOMMENDATIONS.—The Group shall—

(A) conduct a comprehensive assessment of the current situation in Syria, its impact on neighboring countries, resulting regional and geopolitical threats to the United States, and current military, diplomatic, and political efforts to achieve a stable Syria; and

(B) develop recommendations on a military and diplomatic strategy for the United States with respect to the conflict in Syria.

(e) COOPERATION FROM UNITED STATES GOVERNMENT.—

(1) IN GENERAL.—The Group shall receive the full and timely cooperation of the Secretary of Defense, the Secretary of State, and the Director of National Intelligence in providing the Group with analyses, briefings, and other information necessary for the discharge of the duties of the Group.

(2) LIAISON.—The Secretary of Defense, the Secretary of State, and the Director of National Intelligence shall each designate at least one officer or employee of their respective organizations to serve as a liaison officer to the Group.

(f) REPORT.—

(1) FINAL REPORT.—Not later than September 30, 2018, the Group shall submit to the President, the Secretary of Defense, the Committee on Armed Services of the Senate, the Committee on Armed Services of the House of Representatives, the Committee on Foreign Relations of the Senate, and the Committee on Foreign Affairs of the House of Representatives a report on the findings, conclusions, and recommendations of the Group under this section. The report shall do each of the following:

(A) Assess the current security, political, humanitarian, and economic situation in Syria.

(B) Assess the current participation and objectives of various external actors in Syria.

(C) Assess the consequences of continued conflict in Syria.

(D) Provide recommendations for a diplomatic resolution of the conflict in Syria, including options for a gradual political transition to a post-Assad Syria and actions necessary for reconciliation.

(E) Provide a roadmap for a United States and coalition strategy to reestablish security and governance in Syria, including recommendations for the synchronization of stabilization, development, counterterrorism, and reconstruction efforts.

(F) Address any other matters with respect to the conflict in Syria that the Group considers appropriate.

(2) INTERIM BRIEFING.—Not later than June 30, 2018, the Group shall provide to the Committees on Armed Services of the Senate and the House of Representatives a briefing on the status of its review and assessment under subsection (d), together with a discussion of any interim recommendations developed by the Group as of the date of the briefing.

(3) FORM OF REPORT.—The report submitted to Congress under paragraph (1) shall be submitted in unclassified form, but may include a classified annex.

(g) FACILITATION.—The United States Institute of Peace shall take appropriate actions to facilitate the Group in the discharge of its duties under this section.

(h) TERMINATION.—The Group shall terminate six months after the date on which it submits the report required by subsection (f)(1).

(i) FUNDING.—Of the amounts authorized to be appropriated for fiscal year 2018 for the Department of Defense by this Act, $1,500,000 is available to fund the activities of the Group.

**SA 263.** Mrs. SHAHEEN submitted an amendment intended to be proposed by her to the bill S. 1519, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle G of title X of division A, insert the following:

**SEC. 1088. FOREIGN AGENTS REGISTRATION.**

(a) SHORT TITLE.—This section may be cited as the ''Foreign Agents Registration Modernization and Enforcement Act''.

(b) CIVIL INVESTIGATIVE DEMAND AUTHORITY.—The Foreign Agents Registration Act of 1938 (22 U.S.C. 611 et seq.) is amended—

(1) by redesignating sections 8, 9, 10, 11, 12, 13, and 14 as sections 9, 10, 11, 12, 13, 14, and 16, respectively; and

(2) by inserting after section 7 (22 U.S.C. 617) the following:

''CIVIL INVESTIGATIVE DEMAND AUTHORITY

''SEC. 8. (a) Whenever the Attorney General has reason to believe that any person or enterprise may be in possession, custody, or control of any documentary material relevant to an investigation under this Act, the Attorney General, before initiating a civil or criminal proceeding with respect to the production of such material, may serve a written demand upon such person to produce such material for examination.

''(b) Each such demand under subsection (a) shall—

''(1) state the nature of the conduct constituting the alleged violation which is under investigation and the provision of law applicable to such violation;

''(2) describe the class or classes of documentary material required to be produced under such demand with such definiteness and certainty as to permit such material to be fairly identified;

''(3) state that the demand is immediately returnable or prescribe a return date which will provide a reasonable period within which the material may be assembled and made available for inspection and copying or reproduction; and

''(4) identify the custodian to whom such material shall be made available.

''(c) A demand under subsection (a) may not—

''(1) contain any requirement that would be considered unreasonable if contained in a subpoena duces tecum issued by a court of the United States in aid of grand jury investigation of such alleged violation; or

''(2) require the production of any documentary evidence that would be privileged from disclosure if demanded by a subpoena duces tecum issued by a court of the United States in aid of a grand jury investigation of such alleged violation.''.

(c) INFORMATIONAL MATERIALS.—

(1) DEFINITIONS.—Section 1 of the Foreign Agents Registration Act of 1938, as amended (22 U.S.C. 611) is amended—

(A) in subsection (c), by striking ''Except as provided in subsection (d) hereof,'' and inserting ''Except as provided in subsection (d),''; and

(B) by inserting after subsection (i) the following:

''(j) The term 'informational materials' means any oral, visual, graphic, written, or pictorial information or matter of any kind, including matter published by means of advertising, books, periodicals, newspapers, lectures, broadcasts, motion pictures, or any means or instrumentality of interstate or foreign commerce or otherwise.''.

(2) INFORMATIONAL MATERIALS.—Section 4 of the such Act (22 U.S.C. 614) is amended—

(A) in subsection (a)—

(i) by inserting '', including electronic mail and social media,'' after ''United States mails''; and

(ii) by striking '', not later than forty-eight hours after the beginning of the transmittal thereof, file with the Attorney General two copies thereof'' and inserting ''file such materials with the Attorney General in conjunction with, and at the same intervals as, disclosures required under section 2(b).''; and

(B) in subsection (b)—

(i) by striking ''It shall'' and inserting ''(1) Except as provided in paragraph (2), it shall''; and

(ii) by inserting at the end the following:

''(2) Foreign agents described in paragraph (1) may omit disclosure required under that paragraph in individual messages, posts, or transmissions on social media on behalf of a foreign principal if the social media account or profile from which the information is sent includes a conspicuous statement that—

''(A) the account is operated by, and distributes information on behalf of, the foreign agent; and

''(B) additional information about the account is on file with the Department of Justice in Washington, District of Columbia.

''(3) Informational materials disseminated by an agent of a foreign principal as part of an activity that is exempt from registration, or an activity which by itself would not require registration, need not be filed under this subsection.''.

(d) FEES.—

(1) REPEAL.—The Department of Justice and Related Agencies Appropriations Act, 1993 (title I of Public Law 102–395) is amended, under the heading ''SALARIES AND EXPENSES, GENERAL LEGAL ACTIVITIES'', by striking ''In addition, notwithstanding 31 U.S.C. 3302, for fiscal year 1993 and thereafter, the Attorney General shall establish and collect fees to recover necessary expenses of the Registration Unit (to include salaries, supplies, equipment and training) pursuant to the Foreign Agents Registration Act, and shall credit such fees to this appropriation, to remain available until expended.''.

(2) REGISTRATION FEE.—The Foreign Agents Registration Act of 1938, as amended (22 U.S.C. 611 et seq.), as amended by this Act, is further amended by adding after section 14, as redesignated by subsection (b)(1), the following:

''FEES

''SEC. 15. The Attorney General shall—

''(1) establish and collect a registration fee, as part of the initial filing requirement, to help defray the expenses of the FARA Registration Unit; and

''(2) credit such fees to the amount appropriated to carry out the activities of the National Security Division, which shall remain available until expended.''.

(e) REPORTS TO CONGRESS.—Section 12 of the Foreign Agents Registration Act of 1938, as amended, as redesignated by subsection (b)(1), is amended to read as follows:

''REPORTS TO CONGRESS

''SEC. 12. The Assistant Attorney General for National Security, through the FARA Registration Unit of the National Security Division, shall submit a semiannual report to Congress regarding the administration of this Act. Each report under this section shall include, for the applicable reporting period, the identification of—

''(1) registrations filed pursuant to this Act;

''(2) the nature, sources, and content of political propaganda disseminated and distributed by agents of foreign principal;

''(3) the number of investigations initiated based upon a perceived violation of section 8; and

''(4) the number of such investigations that were referred to the Attorney General for prosecution.''.

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**SA 264.** Mr. MCCAIN submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

Beginning on page 41, strike lines 9 through 16 and insert the following:

(ii) in subparagraph (B)(ii)—

(I) in subclause (IV), by striking the semicolon and inserting ''; and'';

(II) in subclause (V), by striking ''2018 is 90 percent; and'' and inserting ''2018 and each subsequent year through 2023 is 90 percent.''; and

(III) by striking subclause (VI).

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**SA 265.** Mr. MCCAIN submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

Beginning on page 61, strike line 15 and all that follows through page 62, line 13, and insert the following:

''(3) APPLICABLE ANNUAL INFLATION FACTOR.—In paragraph (2), the term 'applicable annual inflation factor' means, for a fiscal year—

''(A) for each of the 1903A enrollee categories described in subparagraphs (C), (D), and (E) of subsection (e)(2), the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from September of the previous fiscal year to September of the fiscal year involved, plus 1 percentage point; and

''(B) for each of the 1903A enrollee categories described in subparagraphs (A) and (B) of subsection (e)(2), the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from September of the previous fiscal year to September of the fiscal year involved, plus 2 percentage points.

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**SA 266.** Mr. MCCAIN submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

On page 40, strike lines 1 through 19 and insert the following:

''(E) 90 percent for calendar quarters in 2020;

''(F) 88 percent for calendar quarters in 2021;

''(G) 86 percent for calendar quarters in 2022;

''(H) 84 percent for calendar quarters in 2023;

''(I) 82 percent for calendar quarters in 2024;

''(J) 80 percent for calendar quarters in 2025;

''(K) 78 percent for calendar quarters in 2026;

''(L) 76 percent for calendar quarters in 2027;

''(M) 74 percent for calendar quarters in 2028; and

''(N) 72 percent for calendar quarters in 2029.''; and

(iv) by adding after and below subparagraph (H) (as added by clause (iii)), the following flush sentence:

''The Federal medical assistance percentage determined for a State and year under subsection (b) shall apply to expenditures for medical assistance to newly eligible individuals (as so described) and expansion enrollees (as so defined), in the case of a State that has elected to cover newly eligible individuals before March 1, 2017, for calendar quarters after 2029, and, in the case of any other State, for calendar quarters (or portions of calendar quarters) after February 28, 2017.''; and

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**SA 267.** Mr. MCCONNELL proposed an amendment to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; as follows:

Strike all after the first word and insert the following:

**1. SHORT TITLE.**

This Act may be cited as the ''Obamacare Repeal Reconciliation Act of 2017''.

**TITLE I**

**SEC. 101. RECAPTURE EXCESS ADVANCE PAYMENTS OF PREMIUM TAX CREDITS.**

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

''(iii) NONAPPLICABILITY OF LIMITATION.—This subparagraph shall not apply to taxable years ending after December 31, 2017, and before January 1, 2020.''.

**SEC. 102. PREMIUM TAX CREDIT.**

(a) PREMIUM TAX CREDIT.—

(1) REPEAL.—

(A) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking section 36B.

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

(b) REPEAL OF ELIGIBILITY DETERMINATIONS.—

(1) IN GENERAL.—The following sections of the Patient Protection and Affordable Care Act are repealed:

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

(B) Section 1412.

(2) EFFECTIVE DATE.—The repeals in paragraph (1) shall take effect on January 1, 2020.

(c) PROTECTING AMERICANS BY REPEAL OF DISCLOSURE AUTHORITY TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.—

(1) IN GENERAL.—Paragraph (21) of section 6103(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

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

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2020.

**SEC. 103. SMALL BUSINESS TAX CREDIT.**

(a) SUNSET.—

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

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

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

**SEC. 104. INDIVIDUAL MANDATE.**

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

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

(2) in paragraph (3)—

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

(B) by striking subparagraph (D).

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

**SEC. 105. EMPLOYER MANDATE.**

(a) IN GENERAL.—

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

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

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

**SEC. 106. FEDERAL PAYMENTS TO STATES.**

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

(b) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

(B) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act in fiscal year 2014 made directly to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $1,000,000.

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

**SEC. 107. MEDICAID.**

The Social Security Act (42 U.S.C. 301 et seq.) is amended—

(1) in section 1902—

(A) in subsection (a)(10)(A), in each of clauses (i)(VIII) and (ii)(XX), by inserting ''and ending December 31, 2019,'' after ''January 1, 2014,''; and

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

(2) in section 1905—

(A) in the first sentence of subsection (b), by inserting ''(50 percent on or after January 1, 2020)'' after ''55 percent'';

(B) in subsection (y)(1), by striking the semicolon at the end of subparagraph (D) and all that follows through ''thereafter''; and

(C) in subsection (z)(2)—

(i) in subparagraph (A), by inserting ''through 2019'' after ''each year thereafter''; and

(ii) in subparagraph (B)(ii)(VI), by striking ''and each subsequent year'';

(3) in section 1915(k)(2), by striking ''during the period described in paragraph (1)'' and inserting ''on or after the date referred to in paragraph (1) and before January 1, 2020'';

(4) in section 1920(e), by adding at the end the following: ''This subsection shall not apply after December 31, 2019.'';

(5) in section 1937(b)(5), by adding at the end the following: ''This paragraph shall not apply after December 31, 2019.''; and

(6) in section 1943(a), by inserting ''and before January 1, 2020,'' after ''January 1, 2014,''.

**SEC. 108. REPEAL OF DSH ALLOTMENT REDUCTIONS.**

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

**SEC. 109. REPEAL OF THE TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS.**

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

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

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

**SEC. 110. REPEAL OF TAX ON OVER-THE-COUNTER MEDICATIONS.**

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

(b) ARCHER MSAs.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by striking ''Such term'' and all that follows through the period.

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

(d) EFFECTIVE DATES.—

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

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

**SEC. 111. REPEAL OF TAX ON HEALTH SAVINGS ACCOUNTS.**

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

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

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

**SEC. 112. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO FLEXIBLE SPENDING ACCOUNTS.**

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

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

**SEC. 113. REPEAL OF TAX ON PRESCRIPTION MEDICATIONS.**

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

''(j) REPEAL.—This section shall apply to calendar years beginning after December 31, 2010, and ending before January 1, 2018.''.

**SEC. 114. REPEAL OF MEDICAL DEVICE EXCISE TAX.**

Section 4191 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

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

**SEC. 115. REPEAL OF HEALTH INSURANCE TAX.**

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

**SEC. 116. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.**

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

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

**SEC. 117. REPEAL OF CHRONIC CARE TAX.**

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

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

**SEC. 118. REPEAL OF MEDICARE TAX INCREASE.**

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

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

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

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

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received after, and taxable years beginning after, December 31, 2017.

**SEC. 119. REPEAL OF TANNING TAX.**

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

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services performed after September 30, 2017.

**SEC. 120. REPEAL OF NET INVESTMENT TAX.**

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

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

**SEC. 121. REMUNERATION.**

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

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

**TITLE II**

**SEC. 201. THE PREVENTION AND PUBLIC HEALTH FUND.**

Subsection (b) of section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11) is amended—

(1) in paragraph (3), by striking ''each of fiscal years 2018 and 2019'' and inserting ''fiscal year 2018''; and

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

**SEC. 202. SUPPORT FOR STATE RESPONSE TO SUBSTANCE ABUSE PUBLIC HEALTH CRISIS AND URGENT MENTAL HEALTH NEEDS.**

(a) IN GENERAL.—There are authorized to be appropriated, and are appropriated, out of monies in the Treasury not otherwise obligated, $750,000,000 for each of fiscal years 2018 and 2019, to the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') to award grants to States to address the substance abuse public health crisis or to respond to urgent mental health needs within the State. In awarding grants under this section, the Secretary may give preference to States with an incidence or prevalence of substance use disorders that is substantial relative to other States or to States that identify mental health needs within their communities that are urgent relative to such needs of other States. Funds appropriated under this subsection shall remain available until expended.

(b) USE OF FUNDS.—Grants awarded to a State under subsection (a) shall be used for one or more of the following public health-related activities:

(1) Improving State prescription drug monitoring programs.

(2) Implementing prevention activities, and evaluating such activities to identify effective strategies to prevent substance abuse.

(3) Training for health care practitioners, such as best practices for prescribing opioids, pain management, recognizing potential cases of substance abuse, referral of patients to treatment programs, and overdose prevention.

(4) Supporting access to health care services provided by Federally certified opioid treatment programs or other appropriate health care providers to treat substance use disorders or mental health needs.

(5) Other public health-related activities, as the State determines appropriate, related to addressing the substance abuse public health crisis or responding to urgent mental health needs within the State.

**SEC. 203. COMMUNITY HEALTH CENTER PROGRAM.**

Effective as if included in the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10, 129 Stat. 87), paragraph (1) of section 221(a) of such Act is amended by inserting '', and an additional $422,000,000 for fiscal year 2017'' after ''2017''.

**SEC. 204. FUNDING FOR COST-SHARING PAYMENTS.**

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

**SEC. 205. REPEAL OF COST-SHARING SUBSIDY PROGRAM.**

(a) IN GENERAL.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is repealed.

(b) EFFECTIVE DATE.—The repeal made by subsection (a) shall apply to cost-sharing reductions (and payments to issuers for such reductions) for plan years beginning after December 31, 2019.

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**SA 268.** Mr. WHITEHOUSE submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. _____. MEDICAL BANKRUPTCY FAIRNESS.**

(a) DEFINITIONS.—

(1) IN GENERAL.—Section 101 of title 11, United States Code, is amended—

(A) by inserting after paragraph (39A) the following:

''(39B) The term 'medical debt' means any debt incurred voluntarily or involuntarily—

''(A) as a result of the diagnosis, cure, mitigation, or treatment of injury, deformity, or disease of an individual; or

''(B) for services performed by a medical professional in the prevention of disease or illness of an individual.

''(39C) The term 'medically distressed debtor' means—

''(A) a debtor who, during the 3 years before the date of the filing of the petition—

''(i) incurred or paid aggregate medical debts for the debtor, a dependent of the debtor, or a nondependent parent, grandparent, sibling, child, grandchild, or spouse of the debtor that were not paid by any third-party payor and were greater than the lesser of—

''(I) 10 percent of the debtor's adjusted gross income (as such term is defined in section 62 of the Internal Revenue Code of 1986); or

''(II) $10,000;

''(ii) did not receive domestic support obligations, or had a spouse or dependent who did not receive domestic support obligations, of at least $10,000 due to a medical issue of the person obligated to pay that would cause the obligor to meet the requirements under clause (i) or (iii), if the obligor was a debtor in a case under this title; or

''(iii) experienced a change in employment status that resulted in a reduction in wages, salaries, commissions, or work hours or resulted in unemployment due to—

''(I) an injury, deformity, or disease of the debtor; or

''(II) care for an injured, deformed, or ill dependent or nondependent parent, grandparent, sibling, child, grandchild, or spouse of the debtor; or

''(B) a debtor who is the spouse of a debtor described in subparagraph (A).''.

(2) CONFORMING AMENDMENTS.—Section 104 of title 11, United States Code, is amended—

(A) in subsection (a), in the matter preceding paragraph (1), by inserting ''101(39C)(A),'' after ''101(19)(A),''; and

(B) in subsection (b), by inserting ''101(39C)(A),'' after ''101(19)(A),''.

(b) EXEMPTIONS.—

(1) EXEMPT PROPERTY.—Section 522 of title 11, United States Code, is amended by adding at the end the following:

''(r)(1) If a medically distressed debtor exempts property listed in subsection (b)(2), the debtor may, in lieu of the exemption provided under subsection (d)(1), elect to exempt

the debtor's aggregate interest, not to exceed $250,000 in value, in property described in paragraph (3) of this subsection.

''(2) If a medically distressed debtor exempts property listed in subsection (b)(3) and the exemption provided under applicable law specifically for the kind of property described in paragraph (3) is for less than $250,000 in value, the debtor may elect to exempt the debtor's aggregate interest, not to exceed $250,000 in value, in any such property.

''(3) The property described in this paragraph is—

''(A) real property or personal property that the debtor or a dependent of the debtor uses as a residence;

''(B) a cooperative that owns property that the debtor or a dependent of the debtor uses as a residence; or

''(C) a burial plot for the debtor or a dependent of the debtor.''.

(2) CONFORMING AMENDMENTS.—Section 104 of title 11, United States Code, is amended—

(A) in subsection (a), in the matter preceding paragraph (1), by inserting ''522(r),'' after ''522(q),''; and

(B) in subsection (b), by inserting ''522(r),'' after ''522(q),''.

(c) WAIVER OF ADMINISTRATIVE REQUIREMENTS.—

(1) CASE UNDER CHAPTER 7.—Section 707(b) of title 11, United States Code, is amended by adding at the end the following:

''(8) Paragraph (2) does not apply in any case in which the debtor is a medically distressed debtor.''.

(2) CASE UNDER CHAPTER 13.—Section 1325(b)(1) of title 11, United States Code, is amended—

(A) in subparagraph (A), by striking ''or'' at the end;

(B) in subparagraph (B), by striking the period at the end and inserting ''; or''; and

(C) by adding at the end the following:

''(C) the debtor is a medically distressed debtor.''.

(d) CREDIT COUNSELING.—Section 109(h)(4) of title 11, United States Code, is amended by inserting ''a medically distressed debtor or'' after ''apply with respect to''.

(e) STUDENT LOAN UNDUE HARDSHIP.—Section 523(a)(8) of title 11, United States Code, is amended by inserting ''the debtor is a medically distressed debtor or'' before ''excepting''.

(f) ATTESTATION BY DEBTOR.—Section 521 of title 11, United States Code, is amended by adding at the end the following:

''(k) If the debtor seeks relief as a medically distressed debtor, the debtor shall file a statement of medical expenses relevant to the determination of whether the debtor is a medically distressed debtor, which statement shall declare under penalty of perjury that such medical expenses were not incurred for the purpose of bringing the debtor within the meaning of the term medically distressed debtor.''.

(g) EFFECTIVE DATE; APPLICATION OF AMENDMENTS.—

(1) EFFECTIVE DATE.—Except as provided in paragraph (2), this section and the amendments made by this section shall take effect on the date of enactment of this Act.

(2) APPLICATION OF AMENDMENTS.—The amendments made by this section shall apply only with respect to cases commenced under title 11, United States Code, on or after the date of enactment of this Act.

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**SA 269.** Mr. REED (for himself, Mr. ROUNDS, Mr. BROWN, Ms. COLLINS, Mr. CARPER, Mr. COONS, Mr. WHITEHOUSE, Mrs. SHAHEEN, Ms. CORTEZ MASTO, and Ms. HIRONO) submitted an amendment intended to be proposed by him to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in Subtitle B of title II, insert the following:

**SEC. _____. REAUTHORIZATION OF DEPARTMENT OF DEFENSE ESTABLISHED PROGRAM TO STIMULATE COMPETITIVE RESEARCH.**

(a) MODIFICATION OF PROGRAM OBJECTIVES.—Subsection (b) of section 257 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103–337; 10 U.S.C. 2358 note) is amended—

(1) by redesignating paragraphs (1) and (2) as paragraphs (2) and (3), respectively;

(2) by inserting before paragraph (2), as redesignated by paragraph (1), the following new paragraph (1):

''(1) To increase the number of university researchers in eligible States capable of performing science and engineering research responsive to the needs of the Department of Defense.''; and

(3) in paragraph (2), as redesignated by paragraph (1), by inserting ''relevant to the mission of the Department of Defense and'' after ''that is''.

(b) MODIFICATION OF PROGRAM ACTIVITIES.—Subsection (c) of such section is amended—

(1) by redesignating paragraph (3) as paragraph (4); and

(2) by inserting after paragraph (2) the following new paragraph (3):

''(3) To provide assistance to science and engineering researchers at institutions of higher education in eligible States through collaboration between Department of Defense laboratories and such researchers.''.

(c) MODIFICATION OF ELIGIBILITY CRITERIA FOR STATE PARTICIPATION.—Subsection (d) of such section is amended—

(1) in paragraph (2)(B), by inserting ''in areas relevant to the mission of the Department of Defense'' after ''programs''; and

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

''(3) The Under Secretary shall not remove a designation of a State under paragraph (2) because the State exceeds the funding levels specified under subparagraph (A) of such paragraph unless the State has exceeded such funding levels for at least two consecutive years.''.

(d) MODIFICATION OF NAME.—

(1) IN GENERAL.—Such section is amended—

(A) in subsections (a) and (e) by striking ''Experimental'' each place it appears and inserting ''Established''; and

(B) in the section heading, by striking ''experimental'' and inserting ''established''.

(2) CLERICAL AMENDMENT.—Such Act is amended, in the table of contents in section 2(b), by striking the item relating to section 257 and inserting the following new item:

''Sec. 257. Defense established program to stimulate competitive research.''.

(3) CONFORMING AMENDMENT.—Section 307 of the 1997 Emergency Supplemental Appropriations Act for Recovery from Natural Disasters, and for Overseas Peacekeeping Efforts, Including Those in Bosnia (Public Law 105–18) is amended by striking ''Experimental'' and inserting ''Established''.

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**SA 270.** Mr. MCCONNELL proposed an amendment to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; as follows:

Strike all after line one and insert the following:

This Act may be cited as the ''Better Care Reconciliation Act of 2017''.

**TITLE I**

**SEC. 101. ELIMINATION OF LIMITATION ON RECAPTURE OF EXCESS ADVANCE PAYMENTS OF PREMIUM TAX CREDITS.**

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

''(iii) NONAPPLICABILITY OF LIMITATION.—This subparagraph shall not apply to taxable years ending after December 31, 2017.''.

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

(a) ELIGIBILITY FOR CREDIT.—

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

(A) by striking ''equals or exceeds 100 percent but does not exceed 400 percent'' in subparagraph (A) and inserting ''does not exceed 350 percent'', and

(B) by striking subparagraph (B) and redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively.

(2) TREATMENT OF CERTAIN ALIENS.—

(A) IN GENERAL.—Paragraph (2) of section 36B(e) of the Internal Revenue Code of 1986 is amended by striking ''an alien lawfully present in the United States'' and inserting ''a qualified alien (within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996)''.

(B) AMENDMENTS TO PATIENT PROTECTION AND AFFORDABLE CARE ACT.—

(i) Section 1411(a)(1) of the Patient Protection and Affordable Care Act is amended by striking ''or an alien lawfully present in the United States'' and inserting ''or a qualified alien (within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996)''.

(ii) Section 1411(c)(2)(B) of such Act is amended by striking ''an alien lawfully present in the United States'' each place it appears in clauses (i)(I) and (ii)(II) and inserting ''a qualified alien (within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996)''.

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

(I) by striking ''not lawfully present in the United States'' and inserting ''not citizens or nationals of the United States or qualified aliens (within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996)'', and

(II) by striking ''INDIVIDUALS NOT LAWFULLY PRESENT'' in the heading and inserting ''CERTAIN ALIENS''.

(b) MODIFICATION OF LIMITATION ON PREMIUM ASSISTANCE AMOUNT.—

(1) USE OF BENCHMARK PLAN.—

(A) IN GENERAL.—Section 36B(b) of the Internal Revenue Code of 1986 is amended—

(i) by striking ''applicable second lowest cost silver plan'' each place it appears in paragraph (2)(B)(i) and (3)(C) and inserting ''applicable median cost benchmark plan'',

(ii) by striking ''such silver plan'' in paragraph (3)(C) and inserting ''such benchmark plan'', and

(iii) in paragraph (3)(B)—

(I) by redesignating clauses (i) and (ii) as clauses (iii) and (iv), respectively, and by striking all that precedes clause (iii) (as so redesignated) and inserting the following:

''(B) APPLICABLE MEDIAN COST BENCHMARK PLAN.—The applicable median cost benchmark plan with respect to any applicable taxpayer is the qualified health plan offered

in the individual market in the rating area in which the taxpayer resides which—

''(i) provides a level of coverage that is designed to provide benefits that are actuarially equivalent to 58 percent of the full actuarial value of the benefits (as determined under rules similar to the rules of paragraphs (2) and (3) of section 1302(d) of the Patient Protection and Affordable Care Act) provided under the plan,

''(ii) has a premium which is the median premium of all qualified health plans described in clause (i) which are offered in the individual market in such rating area (or, in any case in which no such plan has such median premium, has a premium nearest (but not in excess of) such median premium),'', and

(II) by striking ''clause (ii)(I)'' in the flush text at the end and inserting ''clause (iv)(I)''.

(B) WAIVER OF ACTUARIAL VALUE STANDARD FOR BENCHMARK PLANS.—Section 36B(b)(3)(B) of the Internal Revenue Code of 1986, as amended by subparagraph (A), is amended by adding at the end the following new sentence: ''If, for any plan year before 2027, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, determines that there will be no plan offered in a rating area in the individual market that meets the level of coverage described in clause (i), the Secretary of the Treasury may increase the 58 percent amount in such clause.''.

(2) MODIFICATION OF APPLICABLE PERCENTAGE.—Section 36B(b)(3)(A) of the Internal Revenue Code of 1986 is amended—

(A) in clause (i), by striking ''from the initial premium percentage'' and all that follows and inserting ''from the initial percentage to the final percentage specified in such table for such income tier with respect to a taxpayer of the age involved:

| ''In the case of household income (expressed as a percent of the poverty line) within the following income tier: | Up to Age 29 | | Age 30-39 | | Age 40-49 | | Age 50-59 | | Over Age 59 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Initial % | Final % | Initial % | Final % | Initial % | Final % | Initial % | Final % | Initial % | Final % |
| Up to 100% | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 100%-133% | 2 | 2.5 | 2 | 2.5 | 2 | 2.5 | 2 | 2.5 | 2 | 2.5 |
| 133%-150% | 2.5 | 4 | 2.5 | 4 | 2.5 | 4 | 2.5 | 4 | 2.5 | 4 |
| 150%-200% | 4 | 4.3 | 4 | 5.3 | 4 | 6.3 | 4 | 7.3 | 4 | 8.3 |
| 200%-250% | 4.3 | 4.3 | 5.3 | 5.9 | 6.3 | 8.05 | 7.3 | 9 | 8.3 | 10 |
| 250%-300% | 4.3 | 4.3 | 5.9 | 5.9 | 8.05 | 8.35 | 9 | 10.5 | 10 | 11.5 |
| 300%-350% | 4.3 | 6.4 | 5.9 | 8.9 | 8.35 | 12.5 | 10.5 | 15.8 | 11.5 | 16.2'', |

(B) by striking ''0.504'' in clause (ii)(III) and inserting ''0.4'', and

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

''(iii) AGE DETERMINATIONS.—For purposes of clause (i), the age of the taxpayer taken into account under clause (i) with respect to any taxable year is the age attained before the close of the taxable year by the oldest individual taken into account on such taxpayer's return who is covered by a qualified health plan taken into account under paragraph (2)(A).''.

(c) ELIMINATION OF ELIGIBILITY EXCEPTIONS FOR EMPLOYER-SPONSORED COVERAGE.—

(1) IN GENERAL.—Section 36B(c)(2) of the Internal Revenue Code of 1986 is amended by striking subparagraph (C).

(2) AMENDMENTS RELATED TO QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 36B(c)(4) of such Code is amended—

(A) by striking ''which constitutes affordable coverage'' in subparagraph (A), and

(B) by striking subparagraphs (B), (C), (E), and (F) and redesignating subparagraph (D) as subparagraph (B).

(d) MODIFICATIONS TO DEFINITION OF QUALIFIED HEALTH PLAN.—

(1) IN GENERAL.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986 is amended by inserting at the end the following new sentence: ''Such term shall not include a plan that includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).''.

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

(e) ALLOWANCE OF CREDIT FOR CATASTROPHIC PLANS.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986, as amended by this Act, is amended by striking '', except that such term shall not include a qualified health plan that is a catastrophic plan described in section 1302(e) of such Act''.

(f) INCREASED PENALTY ON ERRONEOUS CLAIMS OF CREDIT.—Section 6676(a) of the Internal Revenue Code of 1986 is amended by inserting ''(25 percent in the case of a claim for refund or credit relating to the health insurance coverage credit under section 36B)'' after ''20 percent''.

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

**SEC. 103. MODIFICATIONS TO SMALL BUSINESS TAX CREDIT.**

(a) SUNSET.—

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

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

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

(b) DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT FOR PLAN WHICH DOES NOT INCLUDE PROTECTIONS FOR LIFE.—

(1) IN GENERAL.—Subsection (h) of section 45R of the Internal Revenue Code of 1986 is amended—

(A) by striking ''Any term'' and inserting the following:

''(1) IN GENERAL.—Any term'', and

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

''(2) EXCLUSION OF CERTAIN HEALTH PLANS.—The term 'qualified health plan' does not include any health plan that includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).''.

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

**SEC. 104. INDIVIDUAL MANDATE.**

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

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

(2) in paragraph (3)—

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

(B) by striking subparagraph (D).

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

**SEC. 105. EMPLOYER MANDATE.**

(a) IN GENERAL.—

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

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

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

**SEC. 106. STATE STABILITY AND INNOVATION PROGRAM.**

(a) IN GENERAL.—Section 2105 of the Social Security Act (42 U.S.C. 1397ee) is amended by adding at the end the following new subsections:

''(h) SHORT-TERM ASSISTANCE TO ADDRESS COVERAGE AND ACCESS DISRUPTION AND PROVIDE SUPPORT FOR STATES.—

''(1) APPROPRIATION.—There are authorized to be appropriated, and are appropriated, out of monies in the Treasury not otherwise obligated, $15,000,000,000 for each of calendar years 2018 and 2019, and $10,000,000,000 for each of calendar years 2020 and 2021, to the Administrator of the Centers for Medicare & Medicaid Services (in this subsection and subsection (i) referred to as the 'Administrator') to fund arrangements with health insurance issuers to assist in the purchase of health benefits coverage by addressing coverage and access disruption and responding to urgent health care needs within States. Funds appropriated under this paragraph shall remain available until expended.

''(2) PARTICIPATION REQUIREMENTS.—

''(A) GUIDANCE.—Not later than 30 days after the date of enactment of this subsection, the Administrator shall issue guidance to health insurance issuers regarding how to submit a notice of intent to participate in the program established under this subsection.

''(B) NOTICE OF INTENT TO PARTICIPATE.—To be eligible for funding under this subsection, a health insurance issuer shall submit to the Administrator a notice of intent to participate at such time (but, in the case of funding for calendar year 2018, not later than 35 days after the date of enactment of this subsection and, in the case of funding for calendar year 2019, 2020, 2021, 2022, 2023, 2024, 2025, or 2026, not later than March 31 of the previous year) and in such form and manner as specified by the Administrator and containing—

''(i) a certification that the health insurance issuer will use the funds in accordance with the requirements of paragraph (5); and

''(ii) such information as the Administrator may require to carry out this subsection.

''(3) PROCEDURE FOR DISTRIBUTION OF FUNDS.—The Administrator shall determine an appropriate procedure for providing and distributing funds under this subsection that includes reserving an amount equal to 1 percent of the amounts appropriated under paragraph (1) for a calendar year for providing and distributing funds to health insurance issuers in States where the cost of insurance premiums are at least 75 percent higher than the national average.

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

''(5) USE OF FUNDS.—Funds provided to a health insurance issuer under paragraph (1) or (6) shall be subject to the requirements of paragraphs (1)(D) and (7) of subsection (i) in the same manner as such requirements apply to States receiving payments under subsection (i) and shall be used only for the activities specified in paragraph (1)(A)(ii) of subsection (i).

''(6) ADDITIONAL SUPPORT FOR STABILIZING PREMIUMS AND PROMOTING CHOICE IN PLANS OFFERED IN THE INDIVIDUAL MARKET.—

''(A) APPROPRIATION.—In addition to the amounts appropriated under paragraph (1), there is appropriated, out of any money in the Treasury not otherwise obligated, $10,000,000,000 for each of calendar years 2020 through 2026, for the purpose of funding arrangements with health insurance issuers to support the offering of qualified health plans in States in which such issuers also offer coverage in accordance with section 212(a) of the Better Care Reconciliation Act.

''(B) USE OF FUNDS.—

''(i) IN GENERAL.—The Administrator shall use amounts appropriated under subparagraph (A) to establish a Federal fund for the purpose of providing health insurance coverage by making payments to health insurance issuers that offer a plan in accordance with section 212(a) of the Better Care Reconciliation Act, to assist such health insurance issuers in covering high risk individuals enrolled in qualified health plans through an Exchange in rating areas in which coverage is offered in accordance with section 212(a) of such Act. The Administrator shall determine an appropriate procedure for making such payments.

''(ii) PRIORITY USES.—In making payments from the amounts appropriated under subparagraph (A), the Administrator shall prioritize payments—

''(I) based on the percentage of rating areas in the State that meet the conditions in section212(b) of such Act; and

''(II) to health plans certified under section 212(b)(2) of such Act in States for which paragraphs (1) through (6) of section 212(c) of such Act are not applicable.

''(i) LONG-TERM STATE STABILITY AND INNOVATION PROGRAM.—

''(1) APPLICATION AND CERTIFICATION REQUIREMENTS.—To be eligible for an allotment of funds under this subsection, a State shall submit to the Administrator an application, not later than March 31, 2018, in the case of allotments for calendar year 2019, and not later than March 31 of the previous year, in the case of allotments for any subsequent calendar year) and in such form and manner as specified by the Administrator, that contains the following:

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

''(i) To establish or maintain a program or mechanism to help high-risk individuals in the purchase of health benefits coverage, including by reducing premium costs for such individuals, who have or are projected to have a high rate of utilization of health services, as measured by cost, and who do not have access to health insurance coverage offered through an employer, enroll in health insurance coverage under a plan offered in the individual market (within the meaning of section 5000A(f)(1)(C) of the Internal Revenue Code of 1986).

''(ii) To establish or maintain a program to enter into arrangements with health insurance issuers to assist in the purchase of health benefits coverage by stabilizing premiums and promoting State health insurance market participation and choice in plans offered in the individual market (within the meaning of section 5000A(f)(1)(C) of the Internal Revenue Code of 1986).

''(iii) To provide payments for health care providers for the provision of health care services, as specified by the Administrator.

''(iv) To provide health insurance coverage by funding assistance to reduce out-of-pocket costs, such as copayments, coinsurance, and deductibles, of individuals enrolled in plans offered in the individual market (within the meaning of section 5000A(f)(1)(C) of the Internal Revenue Code of 1986).

''(B) A certification that the State shall make, from non-Federal funds, expenditures for 1 or more of the activities specified in subparagraph (A) in an amount that is not less than the State percentage required for the year under paragraph (5)(B)(ii).

''(C) A certification that the funds provided under this subsection shall only be used for the activities specified in subparagraph (A).

''(D) A certification that none of the funds provided under this subsection shall be used by the State for an expenditure that is attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure to finance the non-Federal share of expenditures required under any provision of law, including under the State plans established under this title and title XIX or under a waiver of such plans.

''(E) Such other information as necessary for the Administrator to carry out this subsection.

''(2) ELIGIBILITY.—Only the 50 States and the District of Columbia shall be eligible for an allotment and payments under this subsection and all references in this subsection to a State shall be treated as only referring to the 50 States and the District of Columbia.

''(3) ONE-TIME APPLICATION.—If an application of a State submitted under this subsection is approved by the Administrator for a year, the application shall be deemed to be approved by the Administrator for that year and each subsequent year through December 31, 2026.

''(4) LONG-TERM STATE STABILITY AND INNOVATION ALLOTMENTS.—

''(A) APPROPRIATION; TOTAL ALLOTMENT.—For the purpose of providing allotments to States under this subsection, there is appropriated, out of any money in the Treasury not otherwise appropriated—

''(i) for calendar year 2019, $8,000,000,000;

''(ii) for calendar year 2020, $29,000,000,000;

''(iii) for calendar year 2021, $29,000,000,000;

''(iv) for calendar year 2022, $33,200,000,000;

''(v) for calendar year 2023, $33,200,000,000;

''(vi) for calendar year 2024, $33,200,000,000;

''(vii) for calendar year 2025, $33,200,000,000; and

''(viii) for calendar year 2026, $33,200,000,000.

''(B) ALLOTMENTS.—

''(i) IN GENERAL.—In the case of a State with an application approved under this subsection with respect to a year, the Administrator shall allot to the State, in accordance with an allotment methodology specified by the Administrator that ensures that the spending requirements in paragraphs (6) are met for the year and that reserves an amount that is at least 1 percent of the amount appropriated under subparagraph (A) for a calendar year for allotments to each State where the cost of insurance premiums are at least 75 percent higher than the national average, from amounts appropriated for such year under subparagraph (A), such amount as specified by the Administrator with respect to the State and application and year.

''(ii) ANNUAL REDISTRIBUTION OF PREVIOUS YEAR'S UNUSED FUNDS.—

''(I) IN GENERAL.— In carrying out clause (i), with respect to a year (beginning with 2021), the Administrator shall, not later than March 31 of such year—

''(aa) determine the amount of funds, if any, remaining unused under subparagraph (A) from the previous year; and

''(bb) if the Administrator determines that any funds so remain from the previous year, redistribute such remaining funds in accordance with an allotment methodology specified by the Administrator to States that have submitted an application approved under this subsection for the year.

''(II) APPLICABLE STATE PERCENTAGE.—The State percentage specified for a year in paragraph (5)(B)(ii) shall apply to funds redistributed under subclause (I) in that year.

''(C) AVAILABILITY OF ALLOTTED STATE FUNDS.—

''(i) IN GENERAL.—Amounts allotted to a State pursuant to subparagraph (B)(i) for a year shall remain available for expenditure by the State through the end of the second succeeding year.

''(ii) AVAILABILITY OF AMOUNTS REDISTRIBUTED.—Amounts redistributed to a State under subparagraph (B)(ii) in a year shall be available for expenditure by the State through the end of the second succeeding year.

''(5) PAYMENTS.—

''(A) ANNUAL PAYMENT OF ALLOTMENTS.—Subject to subparagraph (B), the Administrator shall pay to each State that has an application approved under this subsection for a year, from the allotment determined under paragraph (4)(B) for the State for the year, an amount equal to the Federal percentage of the State's expenditures for the year.

''(B) STATE EXPENDITURES REQUIRED BEGINNING 2022.—For purposes of subparagraph (A), the Federal percentage is equal to 100 percent reduced by the State percentage for that year, and the State percentage is equal to—

''(i) in the case of calendar year 2019, 0 percent;

''(ii) in the case of calendar year 2020, 0 percent;

''(iii) in the case of calendar year 2021, 0 percent;

''(iv) in the case of calendar year 2022, 7 percent;

''(v) in the case of calendar year 2023, 14 percent;

''(vi) in the case of calendar year 2024, 21 percent;

''(vii) in the case of calendar year 2025, 28 percent; and

''(viii) in the case of calendar year 2026, 35 percent.

''(C) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—

''(i) IN GENERAL.—If the Administrator deems it appropriate, the Administrator shall make payments under this subsection for each year on the basis of advance estimates of expenditures submitted by the

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

''(ii) MISUSE OF FUNDS.—If the Administrator determines that a State is not using funds paid to the State under this subsection in a manner consistent with the description provided by the State in its application approved under paragraph (1), the Administrator may withhold payments, reduce payments, or recover previous payments to the State under this subsection as the Administrator deems appropriate.

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

''(6) REQUIRED USES.—

''(A) PREMIUM STABILIZATION AND INCENTIVES FOR INDIVIDUAL MARKET PARTICIPATION.—In determining allotments for States under this subsection for each of calendar years 2019, 2020, and 2021, the Administrator shall ensure that at least $5,000,000,000 of the amounts appropriated for each such year under paragraph (4)(A) are used by States for the purposes described in paragraph (1)(A)(ii) and in accordance with guidance issued by the Administrator not later than 30 days after the date of enactment of this subsection that specifies the parameters for the use of funds for such purposes.

''(B) ASSISTANCE WITH OUT-OF-POCKET COSTS.—In determining allotments for States under this subsection for each of calendar years 2020 through 2026, the Administrator shall ensure that at least $15,000,000,000 of the amounts appropriated for each of calendar years 2020 and 2021 under paragraph (4)(A), and at least $14,000,000,000 of the amounts appropriated for each of calendar years 2022 through 2026 under such paragraph, are used by States for the purposes described in paragraph (1)(A)(iv) and in accordance with guidance issued by the Administrator not later than September 1, 2019, that specifies the parameters for the use of funds for such purposes.

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

(b) OTHER TITLE XXI AMENDMENTS.—

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

(A) in subsection (a), in the matter preceding paragraph (1), by striking ''The purpose'' and inserting ''Except with respect to short-term assistance activities under section 2105(h) and the Long-Term State Stability and Innovation Program established in section 2105(i), the purpose''; and

(B) in subsection (b), in the matter preceding paragraph (1), by inserting ''subsection (a) or (g) of'' before ''section 2105''.

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

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

**SEC. 107. BETTER CARE RECONCILIATION IMPLEMENTATION FUND.**

(a) IN GENERAL.—There is hereby established a Better Care Reconciliation Implementation Fund (referred to in this section as the ''Fund'') within the Department of Health and Human Services to provide for Federal administrative expenses in carrying out this Act.

(b) FUNDING.—There is appropriated to the Fund, out of any funds in the Treasury not otherwise appropriated, $500,000,000.

**SEC. 108. REPEAL OF THE TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS.**

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

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

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

**SEC. 109. REPEAL OF TAX ON OVER-THE-COUNTER MEDICATIONS.**

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

(b) ARCHER MSAs.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by striking ''Such term'' and all that follows through the period.

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

(d) EFFECTIVE DATES.—

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

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

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

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

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

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

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

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

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

**SEC. 112. REPEAL OF TAX ON PRESCRIPTION MEDICATIONS.**

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

''(j) REPEAL.—This section shall apply to calendar years beginning after December 31, 2010, and ending before January 1, 2018.''.

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

Section 4191 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

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

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

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

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

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

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

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

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

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

**SEC. 117. REPEAL OF TANNING TAX.**

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

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services performed after September 30, 2017.

**SEC. 118. PURCHASE OF INSURANCE FROM HEALTH SAVINGS ACCOUNT.**

(a) PURCHASE OF HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Paragraph (2) of section 223(d) of the Internal Revenue Code of 1986, as amended by section 109(a), is amended—

(A) by striking ''and any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual'' in subparagraph (A) and inserting ''any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual, and any child (as defined in section 152(f)(1)) of such individual who has not attained the age of 27 before the end of such individual's taxable year'',

(B) by striking subparagraph (B) and inserting the following:

''(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Except as provided in subparagraph (C), subparagraph (A) shall not apply to any payment for insurance.'', and

(C) by striking ''or'' at the end of subparagraph (C)(iii), by striking the period at the end of subparagraph (C)(iv) and inserting '', or'', and by adding at the end the following:

''(v) a high deductible health plan but only to the extent of the portion of such expense in excess of—

''(I) any amount allowable as a credit under section 36B for the taxable year with respect to such coverage,

''(II) any amount allowable as a deduction under section 162(l) with respect to such coverage, or

''(III) any amount excludable from gross income with respect to such coverage under section 106 (including by reason of section 125) or 402(l).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to amounts paid for expenses incurred for, and distributions made for, coverage under a high deductible health plan beginning after December 31, 2017.

(b) CONSUMER FREEDOM PLANS.—

(1) IN GENERAL.—Section 223(d)(2)(C) of the Internal Revenue Code of 1986, as amended by subsection (a) and section 122, is amended—

(A) by striking ''or'' at the end of clause (iv), by striking the period at the end of clause (v), and by adding at the end the following:

''(vi) any plan which—

''(I) is offered by a health insurance issuer which meets the conditions described in section 212(b) of the Better Care Reconciliation Act of 2017 for the plan year, and

''(II) would not be permitted to be offered in the market but for such section.'', and

(B) by inserting ''or (vi)'' after ''clause (v)'' in the last sentence thereof.

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

**SEC. 119. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAVINGS ACCOUNT INCREASED TO AMOUNT OF DEDUCTIBLE AND OUT-OF-POCKET LIMITATION.**

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

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

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

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

(2) in subparagraph (B), by striking ''determined by'' and all that follows through '' 'calendar year 2003'.'' and inserting ''determined by substituting 'calendar year 2003' for 'calendar year 1992' in subparagraph (B) thereof.''.

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

**SEC. 120. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CONTRIBUTIONS TO THE SAME HEALTH SAVINGS ACCOUNT.**

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

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

''(A) IN GENERAL.—In the case of individuals who are married to each other, if both spouses are eligible individuals and either spouse has family coverage under a high deductible health plan as of the first day of any month—

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

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

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

''(B) TREATMENT OF ADDITIONAL CONTRIBUTION AMOUNTS.—If both spouses referred to in subparagraph (A) have attained age 55 before the close of the taxable year, the limitation referred to in subparagraph (A)(iii) which is subject to division between the spouses shall include the additional contribution amounts determined under paragraph (3) for both spouses. In any other case, any additional contribution amount determined under paragraph (3) shall not be taken into account under subparagraph (A)(iii) and shall not be subject to division between the spouses.''.

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

**SEC. 121. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT.**

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

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

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

**SEC. 122. EXCLUSION FROM HSAS OF HIGH DEDUCTIBLE HEALTH PLANS WHICH DO NOT INCLUDE PROTECTIONS FOR LIFE.**

(a) IN GENERAL.—Subparagraph (C) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following flush sentence:

''A high deductible health plan shall not be treated as described in clause (v) if such plan includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).''.

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

**SEC. 123. FEDERAL PAYMENTS TO STATES.**

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

(b) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

(B) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act in fiscal year 2014 made directly to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $350,000,000.

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

**SEC. 124. MEDICAID PROVISIONS.**

The Social Security Act is amended—

(1) in section 1902(a)(47)(B) (42 U.S.C. 1396a(a)(47)(B)), by inserting ''and provided that any such election shall cease to be effective on January 1, 2020, and no such election shall be made after that date'' before the semicolon at the end;

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

(3) in section 1920(e) (42 U.S.C. 1396r–1(e)), by striking ''under clause (i)(VIII), clause (i)(IX), or clause (ii)(XX) of subsection (a)(10)(A)'' and inserting ''under clause (i)(VIII) or clause (ii)(XX) of section 1902(a)(10)(A) before January 1, 2020, section 1902(a)(10)(A)(i)(IX),''.

**SEC. 125. MEDICAID EXPANSION.**

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

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

(A) in subsection (a)(10)(A)—

(i) in clause (i)(VIII), by inserting ''and ending December 31, 2019,'' after ''2014,''; and

(ii) in clause (ii), in subclause (XX), by inserting ''and ending December 31, 2017,'' after ''2014,'', and by adding at the end the following new subclause:

''(XXIII) beginning January 1, 2020, who are expansion enrollees (as defined in subsection (nn)(1));''; and

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

''(nn) EXPANSION ENROLLEES.—

''(1) IN GENERAL.—In this title, the term 'expansion enrollee' means an individual—

''(A) who is under 65 years of age;

''(B) who is not pregnant;

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

''(D) who is not described in any of subclauses (I) through (VII) of subsection (a)(10)(A)(i); and

''(E) whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved.

''(2) APPLICATION OF RELATED PROVISIONS.—Any reference in subsection (a)(10)(G), (k), or (gg) of this section or in section 1903, 1905(a), 1920(e), or 1937(a)(1)(B) to individuals described in subclause (VIII) of subsection (a)(10)(A)(i) shall be deemed to include a reference to expansion enrollees.''; and

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

(A) in subsection (y)(1)—

(i) in the matter preceding subparagraph (A), by striking '', with respect to'' and all that follows through ''shall be equal to'' and inserting ''and that has elected to cover newly eligible individuals before March 1, 2017, with respect to amounts expended by such State before January 1, 2020, for medical assistance for newly eligible individuals

described in subclause (VIII) of section 1902(a)(10)(A)(i), and, with respect to amounts expended by such State after December 31, 2019, and before January 1, 2024, for medical assistance for expansion enrollees (as defined in section 1902(nn)(1)), shall be equal to the higher of the percentage otherwise determined for the State and year under subsection (b) (without regard to this subsection) and'';

(ii) in subparagraph (D), by striking ''and'' after the semicolon;

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

''(E) 90 percent for calendar quarters in 2020;

''(F) 85 percent for calendar quarters in 2021;

''(G) 80 percent for calendar quarters in 2022; and

''(H) 75 percent for calendar quarters in 2023.''; and

(iv) by adding after and below subparagraph (H) (as added by clause (iii)), the following flush sentence:

''The Federal medical assistance percentage determined for a State and year under subsection (b) shall apply to expenditures for medical assistance to newly eligible individuals (as so described) and expansion enrollees (as so defined), in the case of a State that has elected to cover newly eligible individuals before March 1, 2017, for calendar quarters after 2023, and, in the case of any other State, for calendar quarters (or portions of calendar quarters) after February 28, 2017.''; and

(B) in subsection (z)(2)—

(i) in subparagraph (A)—

(I) by inserting ''through 2023'' after ''each year thereafter''; and

(II) by striking ''shall be equal to'' and inserting ''and, for periods after December 31, 2019 and before January 1, 2024, who are expansion enrollees (as defined in section 1902(nn)(1)) shall be equal to the higher of the percentage otherwise determined for the State and year under subsection (b) (without regard to this subsection) and''; and

(ii) in subparagraph (B)(ii)—

(I) in subclause (III), by adding ''and'' at the end; and

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

''(IV) 2017 and each subsequent year through 2023 is 80 percent.''.

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

**SEC. 126. RESTORING FAIRNESS IN DSH ALLOTMENTS.**

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

''(C) NON-EXPANSION STATES.—

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

''(I) subparagraph (A) shall not apply to the DSH allotment for such State and fiscal year; and

''(II) the DSH allotment for the State for fiscal year 2020 (including for a non-expansion State that has a DSH allotment determined under paragraph (6)) shall be increased by the amount calculated according to clause (iii).

''(ii) NO CHANGE IN REDUCTION FOR EXPANSION STATES.—In the case of a State that is an expansion State for a fiscal year, the DSH allotment for such State and fiscal year shall be determined as if clause (i) did not apply.

''(iii) AMOUNT CALCULATED.—For purposes of clause (i)(II), the amount calculated according to this clause for a non-expansion State is the following:

''(I) For each State, the Secretary shall calculate a ratio equal to the State's fiscal year 2016 DSH allotment divided by the number of uninsured individuals in the State for such fiscal year (determined on the basis of the most recent information available from the Bureau of the Census).

''(II) The Secretary shall identify the States whose ratio as so determined is below the national average of such ratio for all States.

''(III) The amount calculated pursuant to this clause is an amount that, if added to the State's fiscal year 2016 DSH allotment, would increase the ratio calculated pursuant to subclause (I) up to the national average for all States.

''(iv) DISREGARD OF INCREASE.—The DSH allotment for a non-expansion State for the second, third, and fourth quarters of fiscal year 2024 and fiscal years thereafter shall be determined as if there had been no increase in the State's DSH allotment for fiscal year 2020 under clause (i)(II).

''(v) NON-EXPANSION AND EXPANSION STATE DEFINED.—In this subparagraph:

''(I) The term 'expansion State' means with respect to a fiscal year, a State that, on or after January 1, 2021, provides eligibility under subclause (XXIII) of section 1902(a)(10)(A)(ii) for medical assistance under this title (or provides eligibility for individuals described in such subclause under a waiver of the State plan approved under section 1115).

''(II) The term 'non-expansion State' means, with respect to a fiscal year, a State that is not an expansion State, except that—

''(aa) in the case of a State that provides eligibility under clause (i)(VIII), (ii)(XX), or (ii)(XXIII) of section 1902(a)(10)(A) for medical assistance under this title (or provides eligibility for individuals described in any of such clauses under a waiver of the State plan approved under section 1115) for any quarter occurring during the period that begins on October 1, 2017, and ends on December 31, 2020 the State shall be treated as a non-expansion State for purposes of clause (i) only for quarters beginning on or after the first day of the first month for which the State no longer provides such eligibility; and

''(bb) in the case of a State identified by the Secretary under clause (iii)(II) that is a non-expansion State on January 1, 2021, but which provided such eligibility on January 1, 2020, the DSH allotment for such State for each of fiscal years 2021 through 2023 and the first fiscal quarter of 2024 shall be determined as if the State's DSH allotment for fiscal year 2020 had been increased under clause (i)(II).''.

**SEC. 127. REDUCING STATE MEDICAID COSTS.**

(a) IN GENERAL.—

(1) STATE PLAN REQUIREMENTS.—Section 1902(a)(34) of the Social Security Act (42 U.S.C. 1396a(a)(34)) is amended by striking ''in or after the third month'' and all that follows through ''individual)'' and inserting ''in or after the month in which the individual (or, in the case of a deceased individual, another individual acting on the individual's behalf) made application (or, in the case of an individual who is 65 years of age or older or who is eligible for medical assistance under the plan on the basis of being blind or disabled, in or after the third month before such month)''.

(2) DEFINITION OF MEDICAL ASSISTANCE.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by striking ''in or after the third month before the month in which the recipient makes application for assistance'' and inserting ''in or after the month in which the recipient makes application for assistance, or, in the case of a recipient who is 65 years of age or older or who is eligible for medical assistance on the basis of being blind or disabled at the time application is made, in or after the third month before the month in which the recipient makes application for assistance,''.

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

**SEC. 128. PROVIDING SAFETY NET FUNDING FOR NON-EXPANSION STATES.**

Title XIX of the Social Security Act is amended by inserting after section 1923 (42 U.S.C. 1396r–4) the following new section:

''ADJUSTMENT IN PAYMENT FOR SERVICES OF SAFETY NET PROVIDERS IN NON-EXPANSION STATES

''SEC. 1923A. (a) IN GENERAL.—Subject to the limitations of this section, for each year during the period beginning with fiscal year 2018 and ending with fiscal year 2022, each State that is one of the 50 States or the District of Columbia and that, as of July 1 of the preceding fiscal year, did not provide for eligibility under clause (i)(VIII), (ii)(XX), or (ii)(XXIII) of section 1902(a)(10)(A) for medical assistance under this title (or a waiver of the State plan approved under section 1115) (each such State or District referred to in this section for the fiscal year as a 'non-expansion State') may adjust the payment amounts otherwise provided under the State plan under this title (or a waiver of such plan) to health care providers that provide health care services to individuals enrolled under this title (in this section referred to as 'eligible providers') so long as the payment adjustment to such an eligible provider does not exceed the provider's costs in furnishing health care services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) to individuals who either are eligible for medical assistance under the State plan (or under a waiver of such plan) or have no health insurance or health plan coverage for such services.

''(b) INCREASE IN APPLICABLE FMAP.—Notwithstanding section 1905(b), the Federal medical assistance percentage applicable with respect to expenditures attributable to a payment adjustment under subsection (a) for which payment is permitted under subsection (c) shall be equal to—

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

''(2) 95 percent for calendar quarters in fiscal year 2022.

''(c) ANNUAL ALLOTMENT LIMITATION.—Payment under section 1903(a) shall not be made to a State with respect to any payment adjustment made under this section for all calendar quarters in a fiscal year in excess of the product of $2,000,000,000 multiplied by the ratio of—

''(1) the population of the State with income below 138 percent of the poverty line in 2015 (as determined based the table entitled 'Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age' for the universe of the civilian noninstitutionalized population for whom poverty status is determined based on the 2015 American Community Survey 1–Year Estimates, as published by the Bureau of the Census), to

''(2) the sum of the populations under paragraph (1) for all non-expansion States.

''(d) DISQUALIFICATION IN CASE OF STATE COVERAGE EXPANSION.—If a State is a non-expansion for a fiscal year and provides eligibility for medical assistance described in

subsection (a) during the fiscal year, the State shall no longer be treated as a non-expansion State under this section for any subsequent fiscal years.''.

**SEC. 129. ELIGIBILITY REDETERMINATIONS.**

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

''(J) FREQUENCY OF ELIGIBILITY REDETERMINATIONS.—Beginning on October 1, 2017, and notwithstanding subparagraph (H), in the case of an individual whose eligibility for medical assistance under the State plan under this title (or a waiver of such plan) is determined based on the application of modified adjusted gross income under subparagraph (A) and who is so eligible on the basis of clause (i)(VIII), (ii)(XX), or (ii)(XXIII) of subsection (a)(10)(A), at the option of the State, the State plan may provide that the individual's eligibility shall be redetermined every 6 months (or such shorter number of months as the State may elect).''.

(b) INCREASED ADMINISTRATIVE MATCHING PERCENTAGE.—For each calendar quarter during the period beginning on October 1, 2017, and ending on December 31, 2019, the Federal matching percentage otherwise applicable under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) with respect to State expenditures during such quarter that are attributable to meeting the requirement of section 1902(e)(14) (relating to determinations of eligibility using modified adjusted gross income) of such Act shall be increased by 5 percentage points with respect to State expenditures attributable to activities carried out by the State (and approved by the Secretary) to exercise the option described in subparagraph (J) of such section (relating to eligibility redeterminations made on a 6-month or shorter basis) (as added by subsection (a)) to increase the frequency of eligibility redeterminations.

**SEC. 130. OPTIONAL WORK REQUIREMENT FOR NONDISABLED, NONELDERLY, NONPREGNANT INDIVIDUALS.**

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

''(oo) OPTIONAL WORK REQUIREMENT FOR NONDISABLED, NONELDERLY, NONPREGNANT INDIVIDUALS.—

''(1) IN GENERAL.—Beginning October 1, 2017, subject to paragraph (3), a State may elect to condition medical assistance to a nondisabled, nonelderly, nonpregnant individual under this title upon such an individual's satisfaction of a work requirement (as defined in paragraph (2)).

''(2) WORK REQUIREMENT DEFINED.—In this section, the term 'work requirement' means, with respect to an individual, the individual's participation in work activities (as defined in section 407(d)) for such period of time as determined by the State, and as directed and administered by the State.

''(3) REQUIRED EXCEPTIONS.—States administering a work requirement under this subsection may not apply such requirement to—

''(A) a woman during pregnancy through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

''(B) an individual who is under 19 years of age;

''(C) an individual who is the only parent or caretaker relative in the family of a child who has not attained 6 years of age or who is the only parent or caretaker of a child with disabilities; or

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

''(i) maintains satisfactory attendance at secondary school or the equivalent; or

''(ii) participates in education directly related to employment.''.

(b) INCREASE IN MATCHING RATE FOR IMPLEMENTATION.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following:

''(aa) The Federal matching percentage otherwise applicable under subsection (a) with respect to State administrative expenditures during a calendar quarter for which the State receives payment under such subsection shall, in addition to any other increase to such Federal matching percentage, be increased for such calendar quarter by 5 percentage points with respect to State expenditures attributable to activities carried out by the State (and approved by the Secretary) to implement subsection (oo) of section 1902.''.

**SEC. 131. PROVIDER TAXES.**

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

''(iii) For purposes of clause (i), a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on June 1, 2017, except that—

''(I) for fiscal year 2021, '5.8 percent' shall be substituted for '6 percent' each place it appears;

''(II) for fiscal year 2022, '5.6 percent' shall be substituted for '6 percent' each place it appears;

''(III) for fiscal year 2023, '5.4 percent' shall be substituted for '6 percent' each place it appears;

''(IV) for fiscal year 2024, '5.2 percent' shall be substituted for '6 percent' each place it appears; and

''(V) for fiscal year 2025 and each subsequent fiscal year, '5 percent' shall be substituted for '6 percent' each place it appears.''.

**SEC. 132. PER CAPITA ALLOTMENT FOR MEDICAL ASSISTANCE.**

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

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

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

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

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

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

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

''(1) IN GENERAL.—If a State which is one of the 50 States or the District of Columbia has excess aggregate medical assistance expenditures (as defined in paragraph (2)) for a fiscal year (beginning with fiscal year 2020), the amount of payment to the State under section 1903(a)(1) for each quarter in the following fiscal year shall be reduced by ¼ of the excess aggregate medical assistance payments (as defined in paragraph (3)) for that previous fiscal year. In this section, the term 'State' means only the 50 States and the District of Columbia.

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

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

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

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

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

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

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

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

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

''(5) PER CAPITA BASE PERIOD.—

''(A) IN GENERAL.—In this section, the term 'per capita base period' means, with respect to a State, a period of 8 (or, in the case of a State selecting a period under subparagraph (D), not less than 4) consecutive fiscal quarters selected by the State.

''(B) TIMELINE.—Each State shall submit its selection of a per capita base period to the Secretary not later than January 1, 2018.

''(C) PARAMETERS.—In selecting a per capita base period under this paragraph, a State shall—

''(i) only select a period of 8 (or, in the case of a State selecting a base period under subparagraph (D), not less than 4) consecutive fiscal quarters for which all the data necessary to make determinations required under this section is available, as determined by the Secretary; and

''(ii) shall not select any period of 8 (or, in the case of a State selecting a base period under subparagraph (D), not less than 4) consecutive fiscal quarters that begins with a fiscal quarter earlier than the first quarter of fiscal year 2014 or ends with a fiscal quarter later than the third fiscal quarter of 2017.

''(D) BASE PERIOD FOR LATE-EXPANDING STATES.—

''(i) IN GENERAL.—In the case of a State that did not provide for medical assistance for the 1903A enrollee category described in subsection (e)(2)(D) as of the first day of the fourth fiscal quarter of fiscal year 2015 but which provided for such assistance for such category in a subsequent fiscal quarter that is not later than the fourth quarter of fiscal year 2016, the State may select a per capita base period that is less than 8 consecutive fiscal quarters, but in no case shall the period selected be less than 4 consecutive fiscal quarters.

''(ii) APPLICATION OF OTHER REQUIREMENTS.—Except for the requirement that a per capita base period be a period of 8 consecutive fiscal quarters, all other requirements of this paragraph shall apply to a per capita base period selected under this subparagraph.

''(iii) APPLICATION OF BASE PERIOD ADJUSTMENTS.—The adjustments to amounts for per capita base periods required under subsections (b)(5) and (d)(4)(E) shall be applied to amounts for per capita base periods selected under this subparagraph by substituting 'divided by the ratio that the number of quarters in the base period bears to 4' for 'divided by 2'.

''(E) ADJUSTMENT BY THE SECRETARY.—If the Secretary determines that a State took

actions after the date of enactment of this section (including making retroactive adjustments to supplemental payment data in a manner that affects a fiscal quarter in the per capita base period) to diminish the quality of the data from the per capita base period used to make determinations under this section, the Secretary may adjust the data as the Secretary deems appropriate.

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

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

''(A) for the State's per capita base period (as defined in subsection (a)(5)), the product of—

''(i) the amount of the medical assistance expenditures (as defined in paragraph (2) and adjusted under paragraph (5)) for the State and period, reduced by the amount of any excluded expenditures (as defined in paragraph (3) and adjusted under paragraph (5)) for the State and period otherwise included in such medical assistance expenditures; and

''(ii) the 1903A base period population percentage (as defined in paragraph (4)) for the State; or

''(B) for fiscal year 2019 or a subsequent fiscal year, the amount of the medical assistance expenditures (as defined in paragraph (2)) for the State and fiscal year that is attributable to 1903A enrollees, reduced by the amount of any excluded expenditures (as defined in paragraph (3)) for the State and fiscal year otherwise included in such medical assistance expenditures and includes non-DSH supplemental payments (as defined in subsection (d)(4)(A)(ii)) and payments described in subsection (d)(4)(A)(iii) but shall not be construed as including any expenditures attributable to the program under section 1928 (relating to State pediatric vaccine distribution programs). In applying subparagraph (B), non-DSH supplemental payments (as defined in subsection (d)(4)(A)(ii)) and payments described in subsection (d)(4)(A)(iii) shall be treated as fully attributable to 1903A enrollees.

''(2) MEDICAL ASSISTANCE EXPENDITURES.—In this section, the term 'medical assistance expenditures' means, for a State and fiscal year or per capita base period, the medical assistance payments as reported by medical service category on the Form CMS-64 quarterly expense report (or successor to such a report form, and including enrollment data and subsequent adjustments to any such report, in this section referred to collectively as a 'CMS-64 report') for quarters in the year or base period for which payment is (or may otherwise be) made pursuant to section 1903(a)(1), adjusted, in the case of a per capita base period, under paragraph (5).

''(3) EXCLUDED EXPENDITURES.—In this section, the term 'excluded expenditures' means, for a State and fiscal year or per capita base period, expenditures under the State plan (or under a waiver of such plan) that are attributable to any of the following:

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

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

''(C) SAFETY NET PROVIDER PAYMENT ADJUSTMENTS IN NON-EXPANSION STATES.—Payment adjustments under subsection (a) of section 1923A for which payment is permitted under subsection (c) of such section.

''(D) EXPENDITURES FOR PUBLIC HEALTH EMERGENCIES.—Any expenditures that are subject to a public health emergency exclusion under paragraph (6).

''(4) 1903A BASE PERIOD POPULATION PERCENTAGE.—In this subsection, the term '1903A base period population percentage' means, for a State, the Secretary's calculation of the percentage of the actual medical assistance expenditures, as reported by the State on the CMS–64 reports for calendar quarters in the State's per capita base period, that are attributable to 1903A enrollees (as defined in subsection (e)(1)).

''(5) ADJUSTMENTS FOR PER CAPITA BASE PERIOD.—In calculating medical assistance expenditures under paragraph (2) and excluded expenditures under paragraph (3) for a State for the State's per capita base period, the total amount of each type of expenditure for the State and base period shall be divided by 2.

''(6) AUTHORITY TO EXCLUDE STATE EXPENDITURES FROM CAPS DURING PUBLIC HEALTH EMERGENCY.—

''(A) IN GENERAL.—During the period that begins on January 1, 2020, and ends on December 31, 2024, the Secretary may exclude, from a State's medical assistance expenditures for a fiscal year or portion of a fiscal year that occurs during such period, an amount that shall not exceed the amount determined under subparagraph (B) for the State and year or portion of a year if—

''(i) a public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act existed within the State during such year or portion of a year; and

''(ii) the Secretary determines that such an exemption would be appropriate.

''(B) MAXIMUM AMOUNT OF ADJUSTMENT.—The amount excluded for a State and fiscal year or portion of a fiscal year under this paragraph shall not exceed the amount by which—

''(i) the amount of State expenditures for medical assistance for 1903A enrollees in areas of the State which are subject to a declaration described in subparagraph (A)(i) for the fiscal year or portion of a fiscal year; exceeds

''(ii) the amount of such expenditures for such enrollees in such areas during the most recent fiscal year or portion of a fiscal year of equal length to the portion of a fiscal year involved during which no such declaration was in effect.

''(C) AGGREGATE LIMITATION ON EXCLUSIONS AND ADDITIONAL BLOCK GRANT PAYMENTS.—The aggregate amount of expenditures excluded under this paragraph and additional payments made under section 1903B(c)(3)(E) for the period described in subparagraph (A) shall not exceed $5,000,000,000.

''(D) REVIEW.—If the Secretary exercises the authority under this paragraph with respect to a State for a fiscal year or portion of a fiscal year, the Secretary shall, not later than 6 months after the declaration described in subparagraph (A)(i) ceases to be in effect, conduct an audit of the State's medical assistance expenditures for 1903A enrollees during the year or portion of a year to ensure that all of the expenditures so excluded were made for the purpose of ensuring that the health care needs of 1903A enrollees in areas affected by a public health emergency are met.

''(c) TARGET TOTAL MEDICAL ASSISTANCE EXPENDITURES.—

''(1) CALCULATION.—In this section, the term 'target total medical assistance expenditures' means, for a State for a fiscal year and subject to paragraph (4), the sum of the products, for each of the 1903A enrollee categories (as defined in subsection (e)(2)), of—

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

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

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

''(A) for fiscal year 2020, an amount equal to—

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

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

''(B) for each succeeding fiscal year, an amount equal to—

''(i) the target per capita medical assistance expenditures (under subparagraph (A) or this subparagraph) for the 1903A enrollee category and State for the preceding fiscal year; increased by

''(ii) the applicable annual inflation factor for that succeeding fiscal year.

''(3) APPLICABLE ANNUAL INFLATION FACTOR.—In paragraph (2), the term 'applicable annual inflation factor' means—

''(A) for fiscal years before 2025—

''(i) for each of the 1903A enrollee categories described in subparagraphs (C), (D), and (E) of subsection (e)(2), the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from September of the previous fiscal year to September of the fiscal year involved; and

''(ii) for each of the 1903A enrollee categories described in subparagraphs (A) and (B) of subsection (e)(2), the percentage increase described in clause (i) plus 1 percentage point; and

''(B) for fiscal years after 2024, for all 1903A enrollee categories, the percentage increase in the consumer price index for all urban consumers (U.S. city average) from September of the previous fiscal year to September of the fiscal year involved.

''(4) DECREASE IN TARGET EXPENDITURES FOR REQUIRED EXPENDITURES BY CERTAIN POLITICAL SUBDIVISIONS.—

''(A) IN GENERAL.—In the case of a State that had a DSH allotment under section 1923(f) for fiscal year 2016 that was more than 6 times the national average of such allotments for all the States for such fiscal year and that requires political subdivisions within the State to contribute funds towards medical assistance or other expenditures under the State plan under this title (or under a waiver of such plan) for a fiscal year (beginning with fiscal year 2020), the target total medical assistance expenditures for such State and fiscal year shall be decreased by the amount that political subdivisions in the State are required to contribute under the plan (or waiver) without reimbursement from the State for such fiscal year, other than contributions described in subparagraph (B).

''(B) EXCEPTIONS.—The contributions described in this subparagraph are the following:

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

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

''(II) imposes a local income tax upon its residents.

''(ii) Contributions required by a State from a political subdivision for administrative expenses if the State required such contributions from such subdivision without reimbursement from the State as of January 1, 2017.

''(5) ADJUSTMENTS TO STATE EXPENDITURES TARGETS TO PROMOTE PROGRAM EQUITY ACROSS STATES.—

''(A) IN GENERAL.—Beginning with fiscal year 2020, the target per capita medical assistance expenditures for a 1903A enrollee category, State, and fiscal year, as determined under paragraph (2), shall be adjusted (subject to subparagraph (C)(i)) in accordance with this paragraph.

''(B) ADJUSTMENT BASED ON LEVEL OF PER CAPITA SPENDING FOR 1903A ENROLLEE CATEGORIES.—Subject to subparagraph (C), with respect to a State, fiscal year, and 1903A enrollee category, if the State's per capita categorical medical assistance expenditures (as defined in subparagraph (D)) for the State and category in the preceding fiscal year—

''(i) exceed the mean per capita categorical medical assistance expenditures for the category for all States for such preceding year by not less than 25 percent, the State's target per capita medical assistance expenditures for such category for the fiscal year involved shall be reduced by a percentage that shall be determined by the Secretary but which shall not be less than 0.5 percent or greater than 3 percent; or

''(ii) are less than the mean per capita categorical medical assistance expenditures for the category for all States for such preceding year by not less than 25 percent, the State's target per capita medical assistance expenditures for such category for the fiscal year involved shall be increased by a percentage that shall be determined by the Secretary but which shall not be less than 0.5 percent or greater than 3 percent.

''(C) RULES OF APPLICATION.—

''(i) BUDGET NEUTRALITY REQUIREMENT.—In determining the appropriate percentages by which to adjust States' target per capita medical assistance expenditures for a category and fiscal year under this paragraph, the Secretary shall make such adjustments in a manner that does not result in a net increase in Federal payments under this section for such fiscal year, and if the Secretary cannot adjust such expenditures in such a manner there shall be no adjustment under this paragraph for such fiscal year.

''(ii) ASSUMPTION REGARDING STATE EXPENDITURES.—For purposes of clause (i), in the case of a State that has its target per capita medical assistance expenditures for a 1903A enrollee category and fiscal year increased under this paragraph, the Secretary shall assume that the categorical medical assistance expenditures (as defined in subparagraph (D)(ii)) for such State, category, and fiscal year will equal such increased target medical assistance expenditures.

''(iii) NONAPPLICATION TO LOW-DENSITY STATES.—This paragraph shall not apply to any State that has a population density of less than 15 individuals per square mile, based on the most recent data available from the Bureau of the Census.

''(iv) DISREGARD OF ADJUSTMENT.—Any adjustment under this paragraph to target medical assistance expenditures for a State, 1903A enrollee category, and fiscal year shall be disregarded when determining the target medical assistance expenditures for such State and category for a succeeding year under paragraph (2).

''(v) APPLICATION FOR FISCAL YEARS 2020 AND 2021.—In fiscal years 2020 and 2021, the Secretary shall apply this paragraph by deeming all categories of 1903A enrollees to be a single category.

''(D) PER CAPITA CATEGORICAL MEDICAL ASSISTANCE EXPENDITURES.—

''(i) IN GENERAL.—In this paragraph, the term 'per capita categorical medical assistance expenditures' means, with respect to a State, 1903A enrollee category, and fiscal year, an amount equal to—

''(I) the categorical medical expenditures (as defined in clause (ii)) for the State, category, and year; divided by

''(II) the number of 1903A enrollees for the State, category, and year.

''(ii) CATEGORICAL MEDICAL ASSISTANCE EXPENDITURES.—The term 'categorical medical assistance expenditures' means, with respect to a State, 1903A enrollee category, and fiscal year, an amount equal to the total medical assistance expenditures (as defined in paragraph (2)) for the State and fiscal year that are attributable to 1903A enrollees in the category, excluding any excluded expenditures (as defined in paragraph (3)) for the State and fiscal year that are attributable to 1903A enrollees in the category.

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

''(1) CALCULATION OF BASE AMOUNTS FOR PER CAPITA BASE PERIOD.—For each State the Secretary shall calculate (and provide notice to the State not later than April 1, 2018, of) the following:

''(A) The amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State for the State's per capita base period.

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

''(C) The average per capita medical assistance expenditures for the State for the State's per capita base period equal to—

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

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

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

''(A) the average per capita medical assistance expenditures for the State for the State's per capita base period (calculated under paragraph (1)(C)); increased by

''(B) the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from the last month of the State's per capita base period to September of fiscal year 2019.

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

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

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

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

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

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

''(I) is not made under section 1923;

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

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

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

''(iii) An expenditure described in this clause is an expenditure that meets the criteria specified in subclauses (I), (II), and (III) of clause (ii) and is authorized under section 1115 for the purposes of funding a delivery system reform pool, uncompensated care pool, a designated State health program, or any other similar expenditure (as defined by the Secretary).

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

''(C) For the State's per capita base period, the State's non-DSH supplemental and pool payment percentage is equal to the ratio (expressed as a percentage) of—

''(i) the total amount of non-DSH supplemental expenditures (as defined in subparagraph (A)(ii) and adjusted under subparagraph (E)) and payments described in subparagraph (A)(iii) (and adjusted under subparagraph (E)) for the State for the period; to

''(ii) the amount described in subsection (b)(1)(A) for the State for the State's per capita base period.

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

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

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

''(E) For purposes of subparagraph (C)(i), in calculating the total amount of non-DSH supplemental expenditures and payments described in subparagraph (A)(iii) for a State for the per capita base period, the total amount of such expenditures and the total amount of such payments for the State and base period shall each be divided by 2.

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

''(A) the product of—

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

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

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

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

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

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

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

''(C) BREAST AND CERVICAL CANCER SERVICES ELIGIBLE INDIVIDUAL.—An individual who is eligible for medical assistance under this title only on the basis of section 1902(a)(10)(A)(ii)(XVIII).

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

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

''(ii) is eligible for medical assistance under this title only on the basis of subclause (XII) or (XXI) of section 1902(a)(10)(A)(ii) (or on the basis of a waiver that provides only comparable benefits);

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

''(iv) is eligible for medical assistance under this title and for whom the State is providing a payment or subsidy to an employer for coverage of the individual under a group health plan pursuant to section 1906 or section 1906A (or pursuant to a waiver that provides only comparable benefits).

''(E) BLIND AND DISABLED CHILDREN.—An individual who—

''(i) is a child under 19 years of age; and

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

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

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

''(B) BLIND AND DISABLED.—A category of 1903A enrollees (not described in the previous subparagraph) who—

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

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

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

''(D) EXPANSION ENROLLEES.—A category of 1903A enrollees (not described in a previous subparagraph) who are eligible for medical assistance under this title only on the basis of clause (i)(VIII), (ii)(XX), or (ii)(XXIII) of section 1902(a)(10)(A).

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

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

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

''(f) SPECIAL PAYMENT RULES.—

''(1) APPLICATION IN CASE OF RESEARCH AND DEMONSTRATION PROJECTS AND OTHER WAIVERS.—In the case of a State with a waiver of the State plan approved under section 1115, section 1915, or another provision of this title, this section shall apply to medical assistance expenditures and medical assistance payments under the waiver, in the same manner as if such expenditures and payments had been made under a State plan under this title and the limitations on expenditures under this section shall supersede any other payment limitations or provisions (including limitations based on a per capita limitation) otherwise applicable under such a waiver.

''(2) TREATMENT OF STATES EXPANDING COVERAGE AFTER JULY 1, 2016.—In the case of a State that did not provide for medical assistance for the 1903A enrollee category described in subsection (e)(2)(D) as of July 1, 2016, but which subsequently provides for such assistance for such category, the provisional FY19 per capita target amount for such enrollee category under subsection (d)(5) shall be equal to the provisional FY19 per capita target amount for the 1903A enrollee category described in subsection (e)(2)(E).

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

''(A) the Secretary shall calculate and apply subsections (a) through (e) with respect to the State as if all 1903A enrollee categories for which such expenditure and enrollee data were not satisfactorily submitted were a single 1903A enrollee category; and

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

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

''(h) REQUIRED REPORTING AND AUDITING; TRANSITIONAL INCREASE IN FEDERAL MATCHING PERCENTAGE FOR CERTAIN ADMINISTRATIVE EXPENSES.—

''(1) REPORTING OF CMS–64 DATA.—

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

''(B) REPORTING ON QUALIFIED INPATIENT PSYCHIATRIC HOSPITAL SERVICES.—Not later than 60 days after the date of the enactment of this section, the Secretary shall modify the CMS–64 report form to require that States submit data with respect to medical assistance expenditures for qualified inpatient psychiatric hospital services (as defined in section 1905(h)(3)).

''(C) REPORTING ON CHILDREN WITH COMPLEX MEDICAL CONDITIONS.—Not later than January 1, 2020, the Secretary shall modify the CMS–64 report form to require that States submit data with respect to individuals who—

''(i) are enrolled in a State plan under this title or title XXI or under a waiver of such plan;

''(ii) are under 21 years of age; and

''(iii) have a chronic medical condition or serious injury that—

''(I) affects two or more body systems;

''(II) affects cognitive or physical functioning (such as reducing the ability to perform the activities of daily living, including the ability to engage in movement or mobility, eat, drink, communicate, or breathe independently); and

''(III) either—

''(aa) requires intensive healthcare interventions (such as multiple medications, therapies, or durable medical equipment) and intensive care coordination to optimize health and avoid hospitalizations or emergency department visits; or

''(bb) meets the criteria for medical complexity under existing risk adjustment methodologies using a recognized, publicly available pediatric grouping system (such as the pediatric complex conditions classification system or the Pediatric Medical Complexity Algorithm) selected by the Secretary in close collaboration with the State agencies responsible for administering State plans under this title and a national panel of pediatric, pediatric specialty, and pediatric subspecialty experts.

''(2) AUDITING OF CMS–64 DATA.—The Secretary shall conduct for each State an audit of the number of individuals and expenditures reported through the CMS–64 report for the State's per capita base period, fiscal year 2019, and each subsequent fiscal year, which audit may be conducted on a representative sample (as determined by the Secretary).

''(3) AUDITING OF STATE SPENDING.—The Inspector General of the Department of Health and Human Services shall conduct an audit (which shall be conducted using random sampling, as determined by the Inspector General) of each State's spending under this section not less than once every 3 years.

''(4) TEMPORARY INCREASE IN FEDERAL MATCHING PERCENTAGE TO SUPPORT IMPROVED DATA REPORTING SYSTEMS FOR FISCAL YEARS 2018 AND 2019.—In the case of any State that selects as its per capita base period the most recent 8 consecutive quarter period for which the data necessary to make the determinations required under this section is available, for amounts expended during calendar quarters beginning on or after October 1, 2017, and before October 1, 2019—

''(A) the Federal matching percentage applied under section 1903(a)(3)(A)(i) shall be

increased by 10 percentage points to 100 percent;

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

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

''(5) HHS REPORT ON ADOPTION OF T–MSIS DATA.—Not later than January 1, 2025, the Secretary shall submit to Congress a report making recommendations as to whether data from the Transformed Medicaid Statistical Information System would be preferable to CMS–64 report data for purposes of making the determinations necessary under this section.''.

(b) ENSURING ACCESS TO HOME AND COMMUNITY BASED SERVICES.—Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following new subsection:

''(l) INCENTIVE PAYMENTS FOR HOME AND COMMUNITY-BASED SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish a demonstration project (referred to in this subsection as the 'demonstration project') under which eligible States may make HCBS payment adjustments for the purpose of continuing to provide and improving the quality of home and community-based services provided under a waiver under subsection (c) or (d) or a State plan amendment under subsection (i).

''(2) SELECTION OF ELIGIBLE STATES.—

''(A) APPLICATION.—A State seeking to participate in the demonstration project shall submit to the Secretary, at such time and in such manner as the Secretary shall require, an application that includes—

''(i) an assurance that any HCBS payment adjustment made by the State under this subsection will comply with the health and welfare and financial accountability safeguards taken by the State under subsection (c)(2)(A); and

''(ii) such other information and assurances as the Secretary shall require.

''(B) SELECTION.—The Secretary shall select States to participate in the demonstration project on a competitive basis except that, in making selections under this paragraph, the Secretary shall give priority to any State that is one of the 15 States in the United States with the lowest population density, as determined by the Secretary based on data from the Bureau of the Census.

''(3) TERM OF DEMONSTRATION PROJECT.—The demonstration project shall be conducted for the 4-year period beginning on January 1, 2020, and ending on December 31, 2023.

''(4) STATE ALLOTMENTS AND INCREASED FMAP FOR PAYMENT ADJUSTMENTS.—

''(A) IN GENERAL.—

''(i) ANNUAL ALLOTMENT.—Subject to clause (ii), for each year of the demonstration project, the Secretary shall allot an amount to each State that is an eligible State for the year.

''(ii) LIMITATION ON FEDERAL SPENDING.—The aggregate amount that may be allotted to eligible States under clause (i) for all years of the demonstration project shall not exceed $8,000,000,000, and in no case may the aggregate amount of payments made by the Secretary to eligible States for payment adjustments under this subsection exceed such amount.

''(B) PAYMENTS TO ELIGIBLE STATES AND LIMITATIONS ON PAYMENTS.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), for each year of the demonstration project, notwithstanding section 1905(b), the Federal medical assistance percentage applicable with respect to expenditures by an eligible State that are attributable to HCBS payment adjustments shall be equal to (and shall in no case exceed) 100 percent.

''(ii) LIMITATION ON HCBS PAYMENT ADJUSTMENTS FOR INDIVIDUAL PROVIDERS.—Payment under section 1903(a) shall not be made to an eligible State for expenditures for a year that are attributable to an HCBS payment adjustment that is paid to a single provider and exceeds a percentage which shall be established by the Secretary of the payment otherwise made to the provider.

''(iii) LIMITATION OF PAYMENT TO AMOUNT OF ALLOTMENT.—Payment under section 1903(a) shall not be made to an eligible State for expenditures for a year that are attributable to an HCBS payment adjustment to the extent that the aggregate amount of HCBS payment adjustments made by the State in the year exceeds the amount allotted to the State for the year under subparagraph (A)(i).

''(5) REPORTING AND EVALUATION.—

''(A) IN GENERAL.—As a condition of receiving the increased Federal medical assistance percentage described in paragraph (4)(B)(i), each eligible State shall collect and report information, as determined necessary by the Secretary, for the purposes of providing Federal oversight and evaluating the State's compliance with the health and welfare and financial accountability safeguards taken by the State under subsection (c)(2)(A).

''(B) FORMS.—Expenditures by eligible States on HCBS payment adjustments shall be separately reported on the CMS-64 Form and in T-MSIS.

''(6) DEFINITIONS.—In this subsection:

''(A) ELIGIBLE STATE.—The term 'eligible State' means a State that—

''(i) is one of the 50 States or the District of Columbia;

''(ii) has in effect—

''(I) a waiver under subsection (c) or (d); or

''(II) a State plan amendment under subsection (i);

''(iii) submits an application under paragraph (2)(A); and

''(iv) is selected by the Secretary to participate in the demonstration project.

''(B) HCBS PAYMENT ADJUSTMENT.—The term 'HCBS payment adjustment' means a payment adjustment made by an eligible State to the amount of payment otherwise provided under a waiver under subsection (c) or (d) or a State plan amendment under subsection (i) for a home and community-based service which is provided to a 1903A enrollee (as defined in section 1903A(e)(1)) who is in the enrollee category described in subparagraph (A) or (B) of section 1903A(e)(2).''.

**SEC. 133. FLEXIBLE BLOCK GRANT OPTION FOR STATES.**

Title XIX of the Social Security Act, as amended by section 132, is further amended by inserting after section 1903A the following new section:

**''SEC. 1903B. MEDICAID FLEXIBILITY PROGRAM.**

''(a) IN GENERAL.—Beginning with fiscal year 2020, any State (as defined in subsection (e)) that has an application approved by the Secretary under subsection (b) may conduct a Medicaid Flexibility Program to provide targeted health assistance to program enrollees.

''(b) STATE APPLICATION.—

''(1) IN GENERAL.—To be eligible to conduct a Medicaid Flexibility Program, a State shall submit an application to the Secretary that meets the requirements of this subsection.

''(2) CONTENTS OF APPLICATION.—An application under this subsection shall include the following:

''(A) A description of the proposed Medicaid Flexibility Program and how the State will satisfy the requirements described in subsection (d).

''(B) The proposed conditions for eligibility of program enrollees.

''(C) The applicable program enrollee category (as defined in subsection (e)(1)).

''(D) A description of the types, amount, duration, and scope of services which will be offered as targeted health assistance under the program, including a description of the proposed package of services which will be provided to program enrollees to whom the State would otherwise be required to make medical assistance available under section 1902(a)(10)(A)(i).

''(E) A description of how the State will notify individuals currently enrolled in the State plan for medical assistance under this title of the transition to such program.

''(F) Statements certifying that the State agrees to—

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

''(ii) submit timely and accurate data to the Transformed Medicaid Statistical Information System (T–MSIS);

''(iii) report annually to the Secretary on adult health quality measures implemented under the program and information on the quality of health care furnished to program enrollees under the program as part of the annual report required under section 1139B(d)(1);

''(iv) submit such additional data and information not described in any of the preceding clauses of this subparagraph but which the Secretary determines is necessary for monitoring, evaluation, or program integrity purposes, including—

''(I) survey data, such as the data from Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys;

''(II) birth certificate data; and

''(III) clinical patient data for quality measurements which may not be present in a claim, such as laboratory data, body mass index, and blood pressure; and

''(v) on an annual basis, conduct a report evaluating the program and make such report available to the public.

''(G) An information technology systems plan demonstrating that the State has the capability to support the technological administration of the program and comply with reporting requirements under this section.

''(H) A statement of the goals of the proposed program, which shall include—

''(i) goals related to quality, access, rate of growth targets, consumer satisfaction, and outcomes;

''(ii) a plan for monitoring and evaluating the program to determine whether such goals are being met; and

''(iii) a proposed process for the State, in consultation with the Centers for Medicare & Medicaid Services, to take remedial action to make progress on unmet goals.

''(I) Such other information as the Secretary may require.

''(3) STATE NOTICE AND COMMENT PERIOD.—

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

''(B) NOTICE AND COMMENT PROCESS.—During the notice and comment period described in subparagraph (A), the State shall provide opportunities for a meaningful level of public input, which shall include public hearings on the proposed Medicaid Flexibility Program.

''(4) FEDERAL NOTICE AND COMMENT PERIOD.—The Secretary shall not approve of

any application to conduct a Medicaid Flexibility Program without making such application publicly available for a 30 day notice and comment period.

''(5) TIMELINE FOR SUBMISSION.—

''(A) IN GENERAL.—A State may submit an application under this subsection to conduct a Medicaid Flexibility Program that would begin in the next fiscal year at any time, subject to subparagraph (B).

''(B) DEADLINES.—Each year beginning with 2019, the Secretary shall specify a deadline for submitting an application under this subsection to conduct a Medicaid Flexibility Program that would begin in the next fiscal year, but such deadline shall not be earlier than 60 days after the date that the Secretary publishes the amounts of State block grants as required under subsection (c)(4).

''(c) FINANCING.—

''(1) IN GENERAL.—For each fiscal year during which a State is conducting a Medicaid Flexibility Program, the State shall receive, instead of amounts otherwise payable to the State under this title for medical assistance for program enrollees, the amount specified in paragraph (3)(A).

''(2) AMOUNT OF BLOCK GRANT FUNDS.—

''(A) IN GENERAL.—The block grant amount under this paragraph for a State and year shall be equal to the sum of the amounts determined under subparagraph (B) for each 1903A enrollee category within the applicable program enrollee category for the State and year.

''(B) ENROLLEE CATEGORY AMOUNTS.—

''(i) FOR INITIAL YEAR.—Subject to subparagraph (C), for the first fiscal year in which a 1903A enrollee category is included in the applicable program enrollee category for a Medicaid Flexibility Program conducted by the State, the amount determined under this subparagraph for the State, year, and category shall be equal to the Federal average medical assistance matching percentage (as defined in section 1903A(a)(4)) for the State and year multiplied by the product of—

''(I) the target per capita medical assistance expenditures (as defined in section 1903A(c)(2)) for the State, year, and category; and

''(II) the number of 1903A enrollees in such category for the State for the second fiscal year preceding such first fiscal year, increased by the percentage increase in State population from such second preceding fiscal year to such first fiscal year, based on the best available estimates of the Bureau of the Census.

''(ii) FOR ANY SUBSEQUENT YEAR.—For any fiscal year that is not the first fiscal year in which a 1903A enrollee category is included in the applicable program enrollee category for a Medicaid Flexibility Program conducted by the State, the block grant amount under this paragraph for the State, year, and category shall be equal to the amount determined for the State and category for the most recent previous fiscal year in which the State conducted a Medicaid Flexibility Program that included such category, except that such amount shall be increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) from April of the second fiscal year preceding the fiscal year involved to April of the fiscal year preceding the fiscal year involved.

''(C) CAP ON TOTAL POPULATION OF 1903A ENROLLEES FOR PURPOSES OF BLOCK GRANT CALCULATION.—

''(i) IN GENERAL.—In calculating the amount of a block grant for the first year in which a 1903A enrollee category is included in the applicable program enrollee category for a Medicaid Flexibility Program conducted by the State under subparagraph (B)(i), the total number of 1903A enrollees in such 1903A enrollee category for the State and year shall not exceed the adjusted number of base period enrollees for the State (as defined in clause (ii)).

''(ii) ADJUSTED NUMBER OF BASE PERIOD ENROLLEES.—The term 'adjusted number of base period enrollees' means, with respect to a State and 1903A enrollee category, the number of 1903A enrollees in the enrollee category for the State for the State's per capita base period (as determined under section 1903A(e)(4)), increased by the percentage increase, if any, in the total State population from the last April in the State's per capita base period to April of the fiscal year preceding the fiscal year involved (determined using the best available data from the Bureau of the Census) plus 3 percentage points.

''(D) AVAILABILITY OF ROLLOVER FUNDS.—

''(i) IN GENERAL.—To the extent that the block grant amount available to a State for a fiscal year under this paragraph exceeds the amount of Federal payments made to the State for such fiscal year under paragraph (3)(A), the Secretary shall make such funds available to the State for the succeeding fiscal year if the State—

''(I) satisfies the State maintenance of effort requirement under paragraph (3)(B); and

''(II) is conducting a Medicaid Flexibility Program in such succeeding fiscal year.

''(ii) USE OF FUNDS.—Funds made available to a State under this subparagraph shall only be used for expenditures related to the State plan under this title or to the State Medicaid Flexibility Program.

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

''(A) FEDERAL PAYMENT.—Subject to subparagraphs (D) and (E), the Secretary shall pay to each State conducting a Medicaid Flexibility Program under this section for a fiscal year, from its block grant amount under paragraph (2) for such year, an amount for each quarter of such year equal to the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) of the total amount expended under the program during such quarter as targeted health assistance, and the State is responsible for the balance of the funds to carry out such program.

''(B) STATE MAINTENANCE OF EFFORT EXPENDITURES.—For each year during which a State is conducting a Medicaid Flexibility Program, the State shall make expenditures for targeted health assistance under the program in an amount equal to the product of—

''(i) the block grant amount determined for the State and year under paragraph (2); and

''(ii) the enhanced FMAP described in the first sentence of section 2105(b) for the State and year.

''(C) REDUCTION IN BLOCK GRANT AMOUNT FOR STATES FAILING TO MEET MOE REQUIREMENT.—

''(i) IN GENERAL.—In the case of a State conducting a Medicaid Flexibility Program that makes expenditures for targeted health assistance under the program for a fiscal year in an amount that is less than the required amount for the fiscal year under subparagraph (B), the amount of the block grant determined for the State under paragraph (2) for the succeeding fiscal year shall be reduced by the amount by which such expenditures are less than such required amount.

''(ii) DISREGARD OF REDUCTION.—For purposes of determining the amount of a State block grant under paragraph (2), any reduction made under this subparagraph to a State's block grant amount in a previous fiscal year shall be disregarded.

''(iii) APPLICATION TO STATES THAT TERMINATE PROGRAM.—In the case of a State described in clause (i) that terminates the State Medicaid Flexibility Program under subsection (d)(2)(B) and such termination is effective with the end of the fiscal year in which the State fails to make the required amount of expenditures under subparagraph (B), the reduction amount determined for the State and succeeding fiscal year under clause (i) shall be treated as an overpayment under this title.

''(D) REDUCTION FOR NONCOMPLIANCE.—If the Secretary determines that a State conducting a Medicaid Flexibility Program is not complying with the requirements of this section, the Secretary may withhold payments, reduce payments, or recover previous payments to the State under this section as the Secretary deems appropriate.

''(E) ADDITIONAL FEDERAL PAYMENTS DURING PUBLIC HEALTH EMERGENCY.—

''(i) IN GENERAL.—In the case of a State and fiscal year or portion of a fiscal year for which the Secretary has excluded expenditures under section 1903A(b)(6), if the State has uncompensated targeted health assistance expenditures for the year or portion of a year, the Secretary may make an additional payment to such State equal to the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) for the year or portion of a year of the amount of such uncompensated targeted health assistance expenditures, except that the amount of such payment shall not exceed the amount determined for the State and year or portion of a year under clause (ii).

''(ii) MAXIMUM AMOUNT OF ADDITIONAL PAYMENT.—The amount determined for a State and fiscal year or portion of a fiscal year under this subparagraph shall not exceed the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) for such year or portion of a year of the amount by which—

''(I) the amount of State expenditures for targeted health assistance for program enrollees in areas of the State which are subject to a declaration described in section 1903A(b)(6)(A)(i) for the year or portion of a year; exceeds

''(II) the amount of such expenditures for such enrollees in such areas during the most recent fiscal year involved (or portion of a fiscal year of equal length to the portion of a fiscal year involved) during which no such declaration was in effect.

''(iii) UNCOMPENSATED TARGETED HEALTH ASSISTANCE.—In this subparagraph, the term 'uncompensated targeted health assistance expenditures' means, with respect to a State and fiscal year or portion of a fiscal year, an amount equal to the amount (if any) by which—

''(I) the total amount expended by the State under the program for targeted health assistance for the year or portion of a year; exceeds

''(II) the amount equal to the amount of the block grant (reduced, in the case of a portion of a year, to the same proportion of the full block grant amount that the portion of the year bears to the whole year) divided by the Federal average medical assistance percentage for the year or portion of a year.

''(iv) REVIEW.—If the Secretary makes a payment to a State for a fiscal year or portion of a fiscal year, the Secretary shall, not later than 6 months after the declaration described in section 1903A(b)(6)(A)(i) ceases to be in effect, conduct an audit of the State's targeted health assistance expenditures for program enrollees during the year or portion of a year to ensure that all of the expenditures for which the additional payment was made were made for the purpose of ensuring that the health care needs of program enrollees in areas affected by a public health emergency are met.

''(4) DETERMINATION AND PUBLICATION OF BLOCK GRANT AMOUNT.—Beginning in 2019 and

each year thereafter, the Secretary shall determine for each State, regardless of whether the State is conducting a Medicaid Flexibility Program or has submitted an application to conduct such a program, the amount of the block grant for the State under paragraph (2) which would apply for the upcoming fiscal year if the State were to conduct such a program in such fiscal year, and shall publish such determinations not later than June 1 of each year.

''(d) PROGRAM REQUIREMENTS.—

''(1) IN GENERAL.—No payment shall be made under this section to a State conducting a Medicaid Flexibility Program unless such program meets the requirements of this subsection.

''(2) TERM OF PROGRAM.—

''(A) IN GENERAL.—A State Medicaid Flexibility Program approved under subsection (b)—

''(i) shall be conducted for not less than 1 program period;

''(ii) at the option of the State, may be continued for succeeding program periods without resubmitting an application under subsection (b), provided that—

''(I) the State provides notice to the Secretary of its decision to continue the program; and

''(II) no significant changes are made to the program; and

''(iii) shall be subject to termination only by the State, which may terminate the program by making an election under subparagraph (B).

''(B) ELECTION TO TERMINATE PROGRAM.—

''(i) IN GENERAL.—Subject to clause (ii), a State conducting a Medicaid Flexibility Program may elect to terminate the program effective with the first day after the end of the program period in which the State makes the election.

''(ii) TRANSITION PLAN REQUIREMENT.—A State may not elect to terminate a Medicaid Flexibility Program unless the State has in place an appropriate transition plan approved by the Secretary.

''(iii) EFFECT OF TERMINATION.—If a State elects to terminate a Medicaid Flexibility Program, the per capita cap limitations under section 1903A shall apply effective with the day described in clause (i), and such limitations shall be applied as if the State had never conducted a Medicaid Flexibility Program.

''(3) PROVISION OF TARGETED HEALTH ASSISTANCE.—

''(A) IN GENERAL.—A State Medicaid Flexibility Program shall provide targeted health assistance to program enrollees and such assistance shall be instead of medical assistance which would otherwise be provided to the enrollees under this title.

''(B) CONDITIONS FOR ELIGIBILITY.—

''(i) IN GENERAL.—A State conducting a Medicaid Flexibility Program shall establish conditions for eligibility of program enrollees, which shall be instead of other conditions for eligibility under this title, except that the program must provide for eligibility for program enrollees to whom the State would otherwise be required to make medical assistance available under section 1902(a)(10)(A)(i).

''(ii) MAGI.—Any determination of income necessary to establish the eligibility of a program enrollee for purposes of a State Medicaid Flexibility Program shall be made using modified adjusted gross income in accordance with section 1902(e)(14).

''(4) BENEFITS AND SERVICES.—

''(A) REQUIRED SERVICES.—In the case of program enrollees to whom the State would otherwise be required to make medical assistance available under section 1902(a)(10)(A)(i), a State conducting a Medicaid Flexibility Program shall provide as targeted health assistance the following types of services:

''(i) Inpatient and outpatient hospital services.

''(ii) Laboratory and X-ray services.

''(iii) Nursing facility services for individuals aged 21 and older.

''(iv) Physician services.

''(v) Home health care services (including home nursing services, medical supplies, equipment, and appliances).

''(vi) Rural health clinic services (as defined in section 1905(l)(1)).

''(vii) Federally-qualified health center services (as defined in section 1905(l)(2)).

''(viii) Family planning services and supplies.

''(ix) Nurse midwife services.

''(x) Certified pediatric and family nurse practitioner services.

''(xi) Freestanding birth center services (as defined in section 1905(l)(3)).

''(xii) Emergency medical transportation.

''(xiii) Non-cosmetic dental services.

''(xiv) Pregnancy-related services, including postpartum services for the 12-week period beginning on the last day of a pregnancy.

''(B) OPTIONAL BENEFITS.—A State may, at its option, provide services in addition to the services described in subparagraph (A) as targeted health assistance under a Medicaid Flexibility Program.

''(C) BENEFIT PACKAGES.—

''(i) IN GENERAL.—The targeted health assistance provided by a State to any group of program enrollees under a Medicaid Flexibility Program shall have an aggregate actuarial value that is equal to at least 95 percent of the aggregate actuarial value of the benchmark coverage described in subsection (b)(1) of section 1937 or benchmark-equivalent coverage described in subsection (b)(2) of such section, as such subsections were in effect prior to the enactment of the Patient Protection and Affordable Care Act.

''(ii) AMOUNT, DURATION, AND SCOPE OF BENEFITS.—Subject to clause (i), the State shall determine the amount, duration, and scope with respect to services provided as targeted health assistance under a Medicaid Flexibility Program, including with respect to services that are required to be provided to certain program enrollees under subparagraph (A) except as otherwise provided under such subparagraph.

''(iii) MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE AND PARITY.—The targeted health assistance provided by a State to program enrollees under a Medicaid Flexibility Program shall include mental health services and substance use disorder services and the financial requirements and treatment limitations applicable to such services under the program shall comply with the requirements of section 2726 of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

''(iv) PRESCRIPTION DRUGS.—If the targeted health assistance provided by a State to program enrollees under a Medicaid Flexibility Program includes assistance for covered outpatient drugs, such drugs shall be subject to a rebate agreement that complies with the requirements of section 1927, and any requirements applicable to medical assistance for covered outpatient drugs under a State plan (including the requirement that the State provide information to a manufacturer) shall apply in the same manner to targeted health assistance for covered outpatient drugs under a Medicaid Flexibility Program.

''(D) COST SHARING.—A State conducting a Medicaid Flexibility Program may impose premiums, deductibles, cost-sharing, or other similar charges, except that the total annual aggregate amount of all such charges imposed with respect to all program enrollees in a family shall not exceed 5 percent of the family's income for the year involved.

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

''(A) SINGLE AGENCY.—Designate a single State agency responsible for administering the program.

''(B) ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.—Provide for simplified enrollment processes (such as online enrollment and reenrollment and electronic verification) and coordination with State health insurance exchanges.

''(C) BENEFICIARY PROTECTIONS.—Establish a fair process (which the State shall describe in the application required under subsection (b)) for individuals to appeal adverse eligibility determinations with respect to the program.

''(6) APPLICATION OF REST OF TITLE XIX.—

''(A) IN GENERAL.—To the extent that a provision of this section is inconsistent with another provision of this title, the provision of this section shall apply.

''(B) APPLICATION OF SECTION 1903A.—With respect to a State that is conducting a Medicaid Flexibility Program, section 1903A shall be applied as if program enrollees were not 1903A enrollees for each program period during which the State conducts the program.

''(C) WAIVERS AND STATE PLAN AMENDMENTS.—

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

''(ii) REPLICATION OF WAIVER OR AMENDMENT.—In designing a Medicaid Flexibility Program, a State may mirror provisions of a waiver or State plan amendment described in clause (i) in the program to the extent that such provisions are otherwise consistent with the requirements of this section.

''(iii) EFFECT OF TERMINATION.—In the case of a State described in clause (i) that terminates its program under subsection (d)(2)(B), any waiver or amendment which was limited pursuant to subparagraph (A) shall cease to be so limited effective with the effective date of such termination.

''(D) NONAPPLICATION OF PROVISIONS.—With respect to the design and implementation of Medicaid Flexibility Programs conducted under this section, paragraphs (1), (10)(B), (17), and (23) of section 1902(a), as well as any other provision of this title (except for this section and as otherwise provided by this section) that the Secretary deems appropriate, shall not apply.

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

''(1) APPLICABLE PROGRAM ENROLLEE CATEGORY.—The term 'applicable program enrollee category' means, with respect to a State Medicaid Flexibility Program for a program period, any of the following as specified by the State for the period in its application under subsection (b):

''(A) 2 ENROLLEE CATEGORIES.—Both of the 1903A enrollee categories described in subparagraphs (D) and (E) of section 1903A(e)(2).

''(B) EXPANSION ENROLLEES.—The 1903A enrollee category described in subparagraph (D) of section 1903A(e)(2).

''(C) NONELDERLY, NONDISABLED, NONEXPANSION ADULTS.—The 1903A enrollee category described in subparagraph (E) of section 1903A(e)(2).

''(2) MEDICAID FLEXIBILITY PROGRAM.—The term 'Medicaid Flexibility Program' means a

State program for providing targeted health assistance to program enrollees funded by a block grant under this section.

''(3) PROGRAM ENROLLEE.—

''(A) IN GENERAL.—The term 'program enrollee' means, with respect to a State that is conducting a Medicaid Flexibility Program for a program period, an individual who is a 1903A enrollee (as defined in section 1903A(e)(1)) who is in the applicable program enrollee category specified by the State for the period.

''(B) RULE OF CONSTRUCTION.—For purposes of section 1903A(e)(3), eligibility and enrollment of an individual under a Medicaid Flexibility Program shall be deemed to be eligibility and enrollment under a State plan (or waiver of such plan) under this title.

''(4) PROGRAM PERIOD.—The term 'program period' means, with respect to a State Medicaid Flexibility Program, a period of 5 consecutive fiscal years that begins with either—

''(A) the first fiscal year in which the State conducts the program; or

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

''(5) STATE.—The term 'State' means one of the 50 States or the District of Columbia.

''(6) TARGETED HEALTH ASSISTANCE.—The term 'targeted health assistance' means assistance for health-care-related items and medical services for program enrollees.''.

**SEC. 134. MEDICAID AND CHIP QUALITY PERFORMANCE BONUS PAYMENTS.**

Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended by section 130, is further amended by adding at the end the following new subsection:

''(bb) QUALITY PERFORMANCE BONUS PAYMENTS.—

''(1) INCREASED FEDERAL SHARE.—With respect to each of fiscal years 2023 through 2026, in the case of one of the 50 States or the District of Columbia (each referred to in this subsection as a 'State') that—

''(A) equals or exceeds the qualifying amount (as established by the Secretary) of lower than expected aggregate medical assistance expenditures (as defined in paragraph (4)) for that fiscal year; and

''(B) submits to the Secretary, in accordance with such manner and format as specified by the Secretary and for the performance period (as defined by the Secretary) for such fiscal year—

''(i) information on the applicable quality measures identified under paragraph (3) with respect to each category of Medicaid eligible individuals under the State plan or a waiver of such plan; and

''(ii) a plan for spending a portion of additional funds resulting from application of this subsection on quality improvement within the State plan under this title or under a waiver of such plan,

the Federal matching percentage otherwise applied under subsection (a)(7) for such fiscal year shall be increased by such percentage (as determined by the Secretary) so that the aggregate amount of the resulting increase pursuant to this subsection for the State and fiscal year does not exceed the State allotment established under paragraph (2) for the State and fiscal year.

''(2) ALLOTMENT DETERMINATION.—The Secretary shall establish a formula for computing State allotments under this paragraph for each fiscal year described in paragraph (1) such that—

''(A) such an allotment to a State is determined based on the performance, including improvement, of such State under this title and title XXI with respect to the quality measures submitted under paragraph (3) by such State for the performance period (as defined by the Secretary) for such fiscal year; and

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

''(3) QUALITY MEASURES REQUIRED FOR BONUS PAYMENTS.—For purposes of this subsection, the Secretary shall, pursuant to rulemaking and after consultation with State agencies administering State plans under this title, identify and publish (and update as necessary) peer-reviewed quality measures (which shall include health care and long-term care outcome measures and may include the quality measures that are overseen or developed by the National Committee for Quality Assurance or the Agency for Healthcare Research and Quality or that are identified under section 1139A or 1139B) that are quantifiable, objective measures that take into account the clinically appropriate measures of quality for different types of patient populations receiving benefits or services under this title or title XXI.

''(4) LOWER THAN EXPECTED AGGREGATE MEDICAL ASSISTANCE EXPENDITURES.—In this subsection, the term 'lower than expected aggregate medical assistance expenditures' means, with respect to a State the amount (if any) by which—

''(A) the amount of the adjusted total medical assistance expenditures for the State and fiscal year determined in section 1903A(b)(1) without regard to the 1903A enrollee category described in section 1903A(e)(2)(E); is less than

''(B) the amount of the target total medical assistance expenditures for the State and fiscal year determined in section 1903A(c) without regard to the 1903A enrollee category described in section 1903A(e)(2)(E).''.

**SEC. 135. GRANDFATHERING CERTAIN MEDICAID WAIVERS; PRIORITIZATION OF HCBS WAIVERS.**

(a) MANAGED CARE WAIVERS.—

(1) IN GENERAL.—In the case of a State with a grandfathered managed care waiver, the State may, at its option through a State plan amendment, continue to implement the managed care delivery system that is the subject of such waiver in perpetuity under the State plan under title XIX of the Social Security Act (or a waiver of such plan) without submitting an application to the Secretary for a new waiver to implement such managed care delivery system, so long as the terms and conditions of the waiver involved (other than such terms and conditions that relate to budget neutrality as modified pursuant to section 1903A(f)(1) of the Social Security Act) are not modified.

(2) MODIFICATIONS.—

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

(B) APPROVAL OF MODIFICATION.—

(i) IN GENERAL.—An application described in subparagraph (A) is deemed approved unless the Secretary, not later than 90 days after the date on which the application is submitted, submits to the State—

(I) a denial; or

(II) a request for more information regarding the application.

(ii) ADDITIONAL INFORMATION.—If the Secretary requests additional information, the Secretary has 30 days after a State submission in response to the Secretary's request to deny the application or request more information.

(3) GRANDFATHERED MANAGED CARE WAIVER DEFINED.—In this subsection, the term ''grandfathered managed care waiver'' means the provisions of a waiver or an experimental, pilot, or demonstration project that relate to the authority of a State to implement a managed care delivery system under the State plan under title XIX of such Act (or under a waiver of such plan under section 1115 of such Act) that—

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

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

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

**SEC. 136. COORDINATION WITH STATES.**

Title XIX of the Social Security Act is amended by inserting after section 1904 (42 U.S.C. 1396d) the following:

''COORDINATION WITH STATES

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

''(1) provides for a process under which the Secretary or the Secretary's designee solicits advice from each State's State agency responsible for administering the State plan under this title (or a waiver of such plan) and State Medicaid Director—

''(A) on a regular, ongoing basis on matters relating to the application of this title that are likely to have a direct effect on the operation or financing of State plans under this title (or waivers of such plans); and

''(B) prior to submission of any final proposed rule, plan amendment, waiver request, or proposal for a project that is likely to have a direct effect on the operation or financing of State plans under this title (or waivers of such plans);

''(2) accepts and considers written and oral comments from a bipartisan, nonprofit, professional organization that represents State Medicaid Directors, and from any State agency administering the plan under this title, regarding such proposed rule; and

''(3) incorporates in the preamble to the proposed rule a summary of comments referred to in paragraph (2) and the Secretary's response to such comments.''.

**SEC. 137. OPTIONAL ASSISTANCE FOR CERTAIN INPATIENT PSYCHIATRIC SERVICES.**

(a) STATE OPTION.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)—

(A) in paragraph (16)—

(i) by striking ''and, (B)'' and inserting ''(B)''; and

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

(B) in the subdivision (B) that follows paragraph (29), by inserting ''(other than services described in subparagraph (C) of paragraph (16) for individuals described in such subparagraph)'' after ''patient in an institution for mental diseases''; and

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

''(3) For purposes of subsection (a)(16)(C), the term 'qualified inpatient psychiatric

hospital services' means, with respect to individuals described in such subsection, services described in subparagraph (B) of paragraph (1) that are not otherwise covered under subsection (a)(16)(A) and are furnished—

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

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

''(4) As a condition for a State including qualified inpatient psychiatric hospital services as medical assistance under subsection (a)(16)(C), the State must (during the period in which it furnishes medical assistance under this title for services and individuals described in such subsection)—

''(A) maintain at least the number of licensed beds at psychiatric hospitals owned, operated, or contracted for by the State that were being maintained as of the date of the enactment of this paragraph or, if higher, as of the date the State applies to the Secretary to include medical assistance under such subsection; and

''(B) maintain on an annual basis a level of funding expended by the State (and political subdivisions thereof) other than under this title from non-Federal funds for inpatient services in an institution described in paragraph (3)(A), and for active psychiatric care and treatment provided on an outpatient basis, that is not less than the level of such funding for such services and care as of the date of the enactment of this paragraph or, if higher, as of the date the State applies to the Secretary to include medical assistance under such subsection.''.

(b) SPECIAL MATCHING RATE.—Section 1905(b) of the Social Security Act (42 U.S.C. 1395d(b)) is amended by adding at the end the following: ''Notwithstanding the previous provisions of this subsection, the Federal medical assistance percentage shall be 50 percent with respect to medical assistance for services and individuals described in subsection (a)(16)(C).''.

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

**SEC. 138. ENHANCED FMAP FOR MEDICAL ASSISTANCE TO ELIGIBLE INDIANS.**

Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting ''and with respect to amounts expended by a State as medical assistance for services provided by any other provider under the State plan to an individual who is a member of an Indian tribe who is eligible for assistance under the State plan'' before the period.

**SEC. 139. MEDICAID OPTION TO PROVIDE CONSUMER-FOCUSED COST-SHARING ASSISTANCE FOR LOW-INCOME INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.**

Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), is amended by inserting after section 1906A the following new section:

''CONSUMER-FOCUSED COST-SHARING ASSISTANCE FOR LOW-INCOME INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS

''SEC. 1906B. (a) IN GENERAL.—A State may elect to provide cost-sharing assistance (as defined in subsection (c)) for an eligible low-income individual (as defined in subsection (b)) who is enrolled in a qualified health plan offered on an Exchange if the State meets the requirements of this section and the offering of such assistance is cost-effective (as defined in subsection (d)).

''(b) ELIGIBLE LOW-INCOME INDIVIDUAL DEFINED.—For purposes of this section, the term 'eligible low-income individual' means an individual—

''(1) whose income (as determined under section 1902(e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved;

''(2) who is eligible for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 and is enrolled in such a plan;

''(3) who would be described in subparagraph (D) or (E) of section 1903A(e)(2) if the individual were eligible for medical assistance under the State plan; and

''(4) who satisfies such additional criteria for the provision of cost-sharing assistance under this section as the State may establish.

''(c) COST-SHARING ASSISTANCE DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'cost-sharing assistance' includes amounts expended for all or part of the costs of premiums, deductibles, coinsurance, copayments, or similar charges, and all or part of any amounts paid for medical care (within the meaning of section 213(d) of the Internal Revenue Code of 1986).

''(2) OPTION OF ADDITIONAL BENEFITS.—Such term may include, at the option of a State, such additional benefits as the State may specify.

''(d) COST-EFFECTIVE DEFINED.—

''(1) IN GENERAL.—For purposes of this section, with respect to a State and year, cost-sharing assistance shall be considered to be 'cost-effective' with respect to a State if the aggregate amount of Federal cost-sharing and premium assistance (as defined in paragraph (2)) for the State and year do not exceed the Federal cost-sharing assistance limit (as defined in paragraph (3)) for the State and year.

''(2) AGGREGATE AMOUNT OF FEDERAL COST-SHARING AND PREMIUM ASSISTANCE.—The term 'aggregate amount of Federal cost-sharing and premium assistance' means, for a State and year, the sum of—

''(A) the product of—

''(i) the Federal average medical assistance matching percentage (as defined in section 1903A(a)(4)) for the State and year; and

''(ii) the amount of cost-sharing assistance provided to eligible low-income individuals by the State for the year; and

''(B) the amount of Federal expenditures attributable to advance payments for premium tax credits under section 1412(c)(2) of the Patient Protection and Affordable Care Act made on behalf of eligible low-income individuals in the State for the year.

''(3) FEDERAL COST-SHARING ASSISTANCE LIMIT.—The term 'Federal cost-sharing assistance limit' means, for a State and year, the product of—

''(A) the Federal average medical assistance matching percentage (as defined in section 1903A(a)(4)) for the State and year; and

''(B) the sum of the products, for each of the 1903A enrollee categories described in subparagraph (D) and (E) of section 1903A(e)(2), of—

''(i) the target per capita medical assistance expenditures for the State, year, and category; and

''(ii) the number of eligible low-income individuals in the State for the year who, if they were eligible for medical assistance, would be described in the category.

''(e) OTHER PROVISIONS.—

''(1) TREATMENT AS MEDICAL ASSISTANCE.—Expenditures for cost-sharing assistance provided by a State for a year in accordance with this section shall be considered, for purposes of section 1903, to be expenditures for medical assistance, except that—

''(A) notwithstanding section 1905(b), the Federal medical assistance percentage applicable to the total amount expended for such assistance shall be equal to the Federal average medical assistance matching percentage (as defined in section 1903A(a)(4)) for such State and year; and

''(B) in no case shall the amount of Federal payments made to a State for a year with respect to amounts expended for such assistance exceed the amount of the Federal cost-sharing assistance limit for the State and year applicable under subsection (d)(3).

''(2) SCALING OF ASSISTANCE.—A State may provide cost-sharing assistance under this section on a sliding scale based on income and percentage of full actuarial value that the State may determine.

''(3) NOT CONSIDERED MINIMUM ESSENTIAL COVERAGE.—Cost-sharing assistance provided under this section shall not be considered to be minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

''(4) NONAPPLICATION OF OTHER REQUIREMENTS.—Sections 1902(a)(1) (relating to statewideness), 1902(a)(10)(B) (relating to comparability), 1916, and 1916A (relating to cost-sharing for medical assistance), and any other provision of this title which would be directly contrary to the authority under this section shall not apply to the provision of cost-sharing assistance under this section.''.

**SEC. 140. SMALL BUSINESS HEALTH PLANS.**

(a) TAX TREATMENT OF SMALL BUSINESS HEALTH PLANS.—A small business health plan (as defined in section 801(a) of the Employee Retirement Income Security Act of 1974) shall be treated—

(1) as a group health plan (as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)) for purposes of applying title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) and title XXII of such Act (42 U.S.C. 300bb-1);

(2) as a group health plan (as defined in section 5000(b)(1) of the Internal Revenue Code of 1986) for purposes of applying sections 4980B and 5000 and chapter 100 of the Internal Revenue Code of 1986; and

(3) as a group health plan (as defined in section 733(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)(1))) for purposes of applying parts 6 and 7 of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.).

(b) RULES.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021 et seq.) is amended by adding at the end the following new part:

**''PART 8—RULES GOVERNING SMALL BUSINESS RISK SHARING POOLS**

**''SEC. 801. SMALL BUSINESS HEALTH PLANS.**

''(a) IN GENERAL.—For purposes of this part, the term 'small business health plan' means a fully insured group health plan, offered by a health insurance issuer in the large group market, whose sponsor is described in subsection (b).

''(b) SPONSOR.—The sponsor of a group health plan is described in this subsection if such sponsor—

''(1) is a qualified sponsor and receives certification by the Secretary;

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

''(3) is established as a permanent entity;

''(4) is established for a purpose other than providing health benefits to its members, such as an organization established as a bona fide trade association, franchise, or section 7705 organization; and

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

**"SEC. 802. FILING FEE AND CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.**

''(a) FILING FEE.—A small business health plan shall pay to the Secretary at the time of filing an application for certification under subsection (b) a filing fee in the amount of $5,000, which shall be available to the Secretary for the sole purpose of administering the certification procedures applicable with respect to small business health plans.

''(b) CERTIFICATION.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this part, the Secretary shall prescribe by interim final rule a procedure under which the Secretary—

''(A) will certify a qualified sponsor of a small business health plan, upon receipt of an application that includes the information described in paragraph (2);

''(B) may provide for continued certification of small business health plans under this part;

''(C) shall provide for the revocation of a certification if the applicable authority finds that the small business health plan involved fails to comply with the requirements of this part;

''(D) shall conduct oversight of certified plan sponsors, including periodic review, and consistent with section 504, applying the requirements of sections 518, 519, and 520; and

''(E) will consult with a State with respect to a small business health plan domiciled in such State regarding the Secretary's authority under this part and other enforcement authority under sections 502 and 504.

''(2) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

''(A) Identifying information.

''(B) States in which the plan intends to do business.

''(C) Bonding requirements.

''(D) Plan documents.

''(E) Agreements with service providers.

''(3) REQUIREMENTS FOR CERTIFIED PLAN SPONSORS.—Not later than 6 months after the date of enactment of this part, the Secretary shall prescribe by interim final rule requirements for certified plan sponsors that include requirements regarding—

''(A) structure and requirements for boards of trustees or plan administrators;

''(B) notification of material changes; and

''(C) notification for voluntary termination.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed by the plan sponsor with the applicable State authority of each State in which the small business health plan operates.

''(d) EXPEDITED AND DEEMED CERTIFICATION.—

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

''(2) PENALTY.—The Secretary may assess a penalty against the board of trustees, plan administrator, and plan sponsor (jointly and severally) of a small business health plan sponsor that is deemed certified under paragraph (1) of up to $500,000 in the event the Secretary determines that the application for certification of such small business health plan sponsor was willfully or with gross negligence incomplete or inaccurate.

**"SEC. 803. PARTICIPATION AND COVERAGE REQUIREMENTS.**

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

''(1) each participating employer must be—

''(A) a member of the sponsor;

''(B) the sponsor; or

''(C) an affiliated member of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

''(2) all individuals commencing coverage under the plan after certification under this part must be—

''(A) active or retired owners (including self-employed individuals with or without employees), officers, directors, or employees of, or partners in, participating employers; or

''(B) the dependents of individuals described in subparagraph (A).

''(b) PARTICIPATING EMPLOYERS.—In applying requirements relating to coverage renewal, a participating employer shall not be deemed to be a plan sponsor.

''(c) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to a small business health plan if—

''(1) under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan; and

''(2) information regarding all coverage options available under the plan is made readily available to any employer eligible to participate.

**"SEC. 804. DEFINITIONS; RENEWAL.**

''For purposes of this part:

''(1) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

''(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor, or

''(B) in the case of a sponsor with members which consist of associations, a person who is a member or employee of any such association and elects an affiliated status with the sponsor.

''(2) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(3) FRANCHISOR; FRANCHISEE.—The terms 'franchisor' and 'franchisee' have the meanings given such terms for purposes of sections 436.2(a) through 436.2(c) of title 16, Code of Federal Regulations (including any such amendments to such regulation after the date of enactment of this part) and, for purposes of this part, franchisor or franchisee employers participating in such a group health plan shall not be treated as the employer, co-employer, or joint employer of the employees of another participating franchisor or franchisee employer for any purpose.

''(4) HEALTH PLAN TERMS.—The terms 'group health plan', 'health insurance coverage', and 'health insurance issuer' have the meanings given such terms in section 733.

''(5) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(6) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a small business health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer with or without employees (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(7) SECTION 7705 ORGANIZATION.—The term 'section 7705 organization' means an organization providing services for a customer pursuant to a contract meeting the conditions of subparagraphs (A), (B), (C), (D), and (E) (but not (F)) of section 7705(e)(2) of the Internal Revenue Code of 1986, including an entity that is part of a section 7705 organization control group . For purposes of this part, any reference to 'member' shall include a customer of a section 7705 organization except with respect to references to a 'member' or 'members' in paragraph (1).''.

(c) PREEMPTION RULES.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended by adding at the end the following:

''(f) The provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude a health insurance issuer from offering health insurance coverage in connection with a small business health plan which is certified under part 8.''.

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

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

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

## TITLE II

**SEC. 201. THE PREVENTION AND PUBLIC HEALTH FUND.**

Subsection (b) of section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11) is amended—

(1) in paragraph (3), by striking ''each of fiscal years 2018 and 2019'' and inserting ''fiscal year 2018''; and

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

**SEC. 202. SUPPORT FOR STATE RESPONSE TO OPIOID AND SUBSTANCE ABUSE CRISIS.**

There is authorized to be appropriated, and is appropriated, to the Secretary of Health and Human Services, out of monies in the Treasury not otherwise obligated—

(1) $4,972,000,000 for each of fiscal years 2018 through 2026, to provide grants to States to support substance use disorder treatment and recovery support services for individuals who have or may have mental or substance use disorders, including counseling, medication assisted treatment, and other substance abuse treatment and recovery services as such Secretary determines appropriate; and

(2) $50,400,000 for each of fiscal years 2018 through 2022, for research on addiction and pain related to the substance abuse crisis.

Funds appropriated under this section shall remain available until expended.

**SEC. 203. COMMUNITY HEALTH CENTER PROGRAM.**

Effective as if included in the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10, 129 Stat. 87), paragraph (1) of section 221(a) of such Act is amended by inserting '', and an additional $422,000,000 for fiscal year 2017'' after ''2017''.

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

Section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)(iii)) is amended by inserting after ''(consistent with section 2707(c))'' the following: ''or, for plan years beginning on or after January 1, 2019, 5 to 1 for adults (consistent with section 2707(c)) or such other ratio for adults (consistent with section 2707(c)) as the State may determine''.

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

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

''(4) SUNSET.—Paragraphs (1) through (3) and subsection (d) shall not apply for plan years beginning on or after January 1, 2019, and after such date any reference in law to such paragraphs and subsection shall have no force or effect.

''(5) MEDICAL LOSS RATIO DETERMINED BY THE STATE.—For plan years beginning on or after January 1, 2019, each State shall—

''(A) set the ratio of the amount of premium revenue a health insurance issuer offering group or individual health insurance coverage may expend on non-claims costs to the total amount of premium revenue; and

''(B) determine the amount of any annual rebate required to be paid to enrollees under such coverage if the ratio of the amount of premium revenue expended by the issuer on non-claims costs to the total amount of premium revenue exceeds the ratio set by the State under subparagraph (A).''.

**SEC. 206. STABILIZING THE INDIVIDUAL INSURANCE MARKETS.**

(a) ENROLLMENT WAITING PERIODS.—Section 2702(b)(1) of the Public Health Services Act (42 U.S.C. 300gg–1(b)(1)) is amended by inserting '', and as described in paragraph (3)'' before the period.

(b) CREDITABLE COVERAGE REQUIREMENT.—Section 2702(b)(2) of the Public Health Services Act (42 U.S.C. 300gg–1(b)(2)) is amended by striking ''paragraph (3)'' and inserting ''paragraph (4)''.

(c) APPLICATION OF WAITING PERIODS.—Section 2702(b) of the Public Health Services Act (42 U.S.C. 300gg-1(b)) is amended—

(1) in paragraph (3)—

(A) by striking ''with respect to enrollment periods under paragraphs (1) and (2)'', inserting ''in accordance with this subsection''; and

(B) by redesignating such paragraph as paragraph (4); and

(2) by inserting after paragraph (2), the following:

''(3) WAITING PERIODS.—

''(A) IN GENERAL.—With respect to health insurance coverage that is effective on or after January 1, 2019, a health insurance issuer described in subsection (a) that offers such coverage in the individual market shall impose a 6 month waiting period (as defined in the same manner as such term is defined in section 2704(b)(4) for group health plans) on any individual who enrolls in such coverage and who cannot demonstrate—

''(i) in the case of an individual submitting an application during an open enrollment period, 12 months of continuous creditable coverage without experiencing a significant break in such coverage as described in subparagraphs (A) and (B) of section 2704(c)(2); or

''(ii) in the case of an individual submitting an application during a special enrollment period—

''(I) 12 months of continuous creditable coverage as described in clause (i); or

''(II) at least 1 day of creditable coverage during the 60-day period immediately preceding the date of submission of such application.

''(B) INDIVIDUALS ENROLLED IN OTHER COVERAGE.—Such a waiting period shall not apply to an individual who is enrolled in health insurance coverage in the individual market on the day before the effective date of the coverage in which the individual is newly enrolling.

''(C) WAITING PERIOD DESCRIBED.—For purposes of subparagraph (A)—

''(i) in the case of an individual that submits an application during an open enrollment period or under a special enrollment period for which the individual qualifies, coverage under the plan begins on the first day of the first month that begins 6 months after the date on which the individual submits an application for health insurance coverage; and

''(ii) in the case of an individual that submits an application outside of an open enrollment period and does not qualify for enrollment under a special enrollment period, coverage under the plan begins on the later of—

''(I) the first day of the first month that begins 6 months after the day on which the individual submits an application for health insurance coverage; or

''(II) the first day of the next plan year.

''(D) CERTIFICATES OF CREDITABLE COVERAGE.—The Secretary shall require health insurance issuers and health care sharing ministries (as defined in section 5000A(d)(2)(B) of the Internal Revenue Code of 1986) to provide certification of periods of creditable coverage and waiting periods, in a manner prescribed by the Secretary, for purposes of verifying that the continuous coverage requirements of subparagraph (A) are met.

''(E) CONTINUOUS CREDITABLE COVERAGE DEFINED.—For purposes of this paragraph, the term 'creditable coverage'—

''(i) has the meaning given such term in section 2704(c)(1); and

''(ii) includes membership in a health care sharing ministry (as defined in section 5000A(d)(2)(B) of the Internal Revenue Code of 1986).

''(F) EXCEPTIONS.—Notwithstanding subparagraph (A), a health insurance issuer may not impose a waiting period with respect to the following individuals:

''(i) A newborn who is enrolled in such coverage within 30 days of the date of birth.

''(ii) A child who is adopted or placed for adoption before attaining 18 years of age and who is enrolled in such coverage within 30 days of the date of the adoption.

''(iii) Other individuals, as the Secretary determines appropriate.''.

**SEC. 207. WAIVERS FOR STATE INNOVATION.**

(a) IN GENERAL.—Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) in subparagraph (B)—

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

''(i) a description of how the State plan meeting the requirements of a waiver under this section would, with respect to health insurance coverage within the State—

''(I) take the place of the requirements described in paragraph (2) that are waived; and

''(II) provide for alternative means of, and requirements for, increasing access to comprehensive coverage, reducing average premiums, providing consumers the freedom to purchase the health insurance of their choice, and increasing enrollment in private health insurance; and''; and

(II) in clause (ii), by striking ''that is budget neutral for the Federal Government'' and inserting '', demonstrating that the State plan does not increase the Federal deficit''; and

(ii) in subparagraph (C), by striking ''the law'' and inserting ''a law or has in effect a certification'';

(B) in paragraph (3)—

(i) in the first sentence, by inserting ''or would qualify for a reduction in'' after ''would not qualify for'';

(ii) by adding after the second sentence the following: ''A State may request that all of, or any portion of, such aggregate amount of such credits or reductions be paid to the State as described in the first sentence.'';

(iii) in the paragraph heading, by striking ''PASS THROUGH OF FUNDING'' and inserting ''FUNDING'';

(iv) by striking ''With respect'' and inserting the following:

''(A) PASS THROUGH OF FUNDING.—With respect''; and

(v) by adding at the end the following:

''(B) ADDITIONAL FUNDING.—There is authorized to be appropriated, and is appropriated, to the Secretary of Health and Human Services, out of monies in the Treasury not otherwise obligated, $2,000,000,000 for fiscal year 2017, to remain available until the end of fiscal year 2019, to provide grants to States for purposes of submitting an application for a waiver granted under this section and implementing the State plan under such waiver.

''(C) AUTHORITY TO USE LONG-TERM STATE INNOVATION AND STABILITY ALLOTMENT.—If the State has an application for an allotment under section 2105(i) of the Social Security Act for the plan year, the State may use the funds available under the State's allotment for the plan year to carry out the State plan under this section, so long as such use is consistent with the requirements of paragraphs (1) and (7) of section 2105(i) of such Act (other than paragraph (1)(B) of such section). Any funds used to carry out a State plan under this subparagraph shall not be

considered in determining whether the State plan increases the Federal deficit.''; and

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

''(D) EXPEDITED PROCESS.—The Secretary shall establish an expedited application and approval process that may be used if the Secretary determines that such expedited process is necessary to respond to an urgent or emergency situation with respect to health insurance coverage within a State.'';

(2) in subsection (b)—

(A) in paragraph (1)—

(i) in the matter preceding subparagraph (A)—

(I) by striking ''may'' and inserting ''shall''; and

(II) by striking ''only if'' and inserting ''unless''; and

(ii) by striking ''plan—'' and all that follows through the period at the end of subparagraph (D) and inserting ''application is missing a required element under subsection (a)(1) or that the State plan will increase the Federal deficit, not taking into account any amounts received through a grant under subsection (a)(3)(B).'';

(B) in paragraph (2)—

(i) in the paragraph heading, by inserting ''OR CERTIFY'' after ''LAW'';

(ii) in subparagraph (A), by inserting before the period '', and a certification described in this paragraph is a document, signed by the Governor, and the State insurance commissioner, of the State, that provides authority for State actions under a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B)''; and

(iii) in subparagraph (B)—

(I) in the subparagraph heading, by striking ''OF OPT OUT''; and

(II) by striking '' may repeal a law'' and all that follows through the period at the end and inserting the following: ''may terminate the authority provided under the waiver with respect to the State by—

''(i) repealing a law described in subparagraph (A); or

''(ii) terminating a certification described in subparagraph (A), through a certification for such termination signed by the Governor, and the State insurance commissioner, of the State.'';

(3) in subsection (d)(2)(B), by striking ''and the reasons therefore'' and inserting ''and the reasons therefore, and provide the data on which such determination was made''; and

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

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

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

''(3) may not be cancelled by the Secretary before the expiration of the 8-year period (including any renewal period under paragraph (2)).''.

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

(1) In the case of a State for which a waiver under such section was granted prior to the date of enactment of this Act, such section 1332, as in effect on the day before the date of enactment of this Act shall apply to the waiver and State plan.

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

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

**SEC. 208. ALLOWING ALL INDIVIDUALS PURCHASING HEALTH INSURANCE IN THE INDIVIDUAL MARKET THE OPTION TO PURCHASE A LOWER PREMIUM CATASTROPHIC PLAN.**

(a) IN GENERAL.—Section 1302(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(e)) is amended by adding at the end the following:

''(4) CONSUMER FREEDOM.—For plan years beginning on or after January 1, 2019, paragraph (1)(A) shall not apply with respect to any plan offered in the State.''.

(b) RISK POOLS.—Section 1312(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(c)) is amended—

(1) in paragraph (1), by inserting ''and including, with respect to plan years beginning on or after January 1, 2019, enrollees in catastrophic plans described in section 1302(e)'' after ''Exchange''; and

(2) in paragraph (2), by inserting ''and including, with respect to plan years beginning on or after January 1, 2019, enrollees in catastrophic plans described in section 1302(e)'' after ''Exchange''.

**SEC. 209. APPLICATION OF ENFORCEMENT PENALTIES.**

(a) IN GENERAL.—Section 2723 of the Public Health Service Act (42 U.S.C. 300gg–22) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by inserting ''and of section 1303 of the Patient Protection and Affordable Care Act'' after ''this part''; and

(B) in paragraph (2), by inserting ''or in such section 1303'' after ''this part''; and

(2) in subsection (b)—

(A) in paragraphs (1) and (2)(A), by inserting ''or section 1303 of the Patient Protection and Affordable Care Act'' after ''this part'' each place such term appears;

(B) in paragraph (2)(C)(ii), by inserting ''and section 1303 of the Patient Protection and Affordable Care Act'' after ''this part''.

(b) EFFECT OF WAIVER.—A State waiver pursuant to section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) shall not affect the authority of the Secretary to impose penalties under section 2723 of the Public Health Service Act (42 U.S.C. 300gg–22).

**SEC. 210. FUNDING FOR COST-SHARING PAYMENTS.**

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

**SEC. 211. REPEAL OF COST-SHARING SUBSIDY PROGRAM.**

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

(b) EFFECTIVE DATE.—The repeal made by subsection (a) shall apply to cost-sharing reductions (and payments to issuers for such reductions) for plan years beginning after December 31, 2019.

**SEC. 212. CONDITIONS FOR RECEIVING ADDITIONAL SUPPORT FOR STABILIZING PREMIUMS AND PROMOTING CHOICE IN PLANS OFFERED IN THE INDIVIDUAL MARKET.**

(a) FEDERAL FUNDING FOR PLANS.—If, for any of plan years 2020 through 2026 for which funds are available under subsection (h)(6) of section 2105 of the Social Security Act (42 U.S.C. 1397ee), a health insurance issuer (as defined in section 2791(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(2)) meets the conditions of subsection (b) with respect to an entire rating area within a State (as defined in section 2701(a)(2) of the Public Health Service Act (42 U.S.C. § 300gg(a)(2)), the provisions described in subsection (c) shall be treated as not applying (directly or through reference) for those plan years to health insurance coverage offered off the Exchange by such issuer in the individual market in the rating area in the State for such plan year (other than with respect to health insurance coverage certified under subsection (b)(2)), provided that such coverage offered off the Exchange complies with the applicable State health insurance requirements.

(b) CONDITIONS FOR FEDERAL FUNDING FOR PLANS.—The conditions of this subsection for a health insurance issuer for a plan year are that the health insurance issuer, on or before May 3 of the calendar year preceding the plan year involved—

(1) certifies to the Secretary and the applicable State insurance commissioner that such issuer will apply subsection (a) with respect to health insurance coverage in a rating area within a State for such plan year; and

(2) certifies to the Secretary that such issuer will make available through the Exchange in the rating area in the State in such plan year at least one gold level and one silver level qualified health plan (as described in section 1302(d)(1) of the Patient Protection and Affordable Care Act, 42 U.S.C. 18022(d)(1)) and one health plan that provides the level of coverage described in section 36B(b)(3)(B)(i) of the Internal Revenue Code of 1986.

(c) NON-APPLICABLE PROVISIONS DESCRIBED.—The provisions described in this subsection are the following:

(1) Subsections (b), (c)(1)(B), and (d) of section 1302 of the Patient Protection and Affordable Care Act (42 U.S.C. 18022).

(2) Section 2701(a)(1) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)).

(3) Subsections (a) and (b)(2) of section 2702 of the Public Health Service Act (42 U.S.C. §§ 300gg–1).

(4) Section 2704 of the Public Health Service Act (42 U.S.C. §§ 300gg–3).

(5) Subsections (a) through (j) of section 2705 of the Public Health Service Act (42 U.S.C. §§ 300gg–4).

(6) Section 2707 of the Public Health Service Act (42 U.S.C. 300gg–6).

(7) Section 2708 of the Public Health Service Act (42 U.S.C. 300gg–7).

(8) Section 2713(a) of the Public Health Service Act (42 U.S.C. 300gg–13(a)).

(9) Section 2718(b)(1) of the Public Health Service Act (42 U.S.C. §§ 300gg–18(b)(1)).

(d) CONTINUOUS COVERAGE.—For purposes of section 2702(b) of the Public Health Service Act (42 U.S.C. 300gg–1), health insurance coverage offered off the Exchange in accordance with subsection (a) shall not be deemed creditable coverage, as defined in section 2704(c) of the Public Health Service Act (42 U.S.C. 300gg–3(c)).

(e) NONAPPLICATION OF RISK ADJUSTMENT PROGRAM.—Section 1343 of the Patient Protection and Affordable Care Act (42 U.S.C. 18063) shall not apply to health insurance

coverage offered off the Exchange in accordance with subsection (a) or to the issuer of such coverage with respect to that coverage.

(f) EFFECT OF WAIVER.—A State that receives a waiver under section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) shall not be permitted to use pass through funding under subsection (a)(3)(C) of such section either to provide assistance to individuals who enroll in health insurance coverage offered in accordance with subsection (a) or to make payments to issuers for any health insurance coverage offered in accordance with subsection (a).

(g) FUNDING FOR STATES.—

(1) APPROPRIATION.—There is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated, $2,000,000,000 for the period beginning on January 1, 2020, and ending on December 31, 2026, for the purpose of providing allotments for States in which a health insurance issuer offers coverage in accordance with subsection (a). Amounts paid to any such State from such an allotment shall be used to offset costs attributable to the State's regulation and oversight of such coverage. Funds appropriated under this paragraph shall remain available until expended.

(2) PROCEDURE FOR DISTRIBUTION OF FUNDS.—The Secretary of Health and Human Services shall determine an appropriate procedure for providing and distributing funds under this subsection.

(h) TAX CREDIT NOT AVAILABLE.—Health insurance coverage offered off the Exchange in accordance with subsection (a) shall not be taken into account as a qualified health plan for purposes of calculating the amount of the premium tax credit under section 36B of the Internal Revenue Code of 1986.

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**SA 271.** Mr. ENZI submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; as follows:

Strike all after the first line and insert the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Obamacare Repeal Reconciliation Act of 2017''.

**TITLE I**

**SEC. 101. RECAPTURE EXCESS ADVANCE PAYMENTS OF PREMIUM TAX CREDITS.**

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

''(iii) NONAPPLICABILITY OF LIMITATION.—This subparagraph shall not apply to taxable years ending after December 31, 2017, and before January 1, 2020.''.

**SEC. 102. PREMIUM TAX CREDIT.**

(a) PREMIUM TAX CREDIT.—

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

(A) IN GENERAL.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986 is amended by inserting before the period at the end the following: ''or a plan that includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest)''.

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

(2) REPEAL.—

(A) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking section 36B.

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

(b) REPEAL OF ELIGIBILITY DETERMINATIONS.—

(1) IN GENERAL.—The following sections of the Patient Protection and Affordable Care Act are repealed:

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

(B) Section 1412.

(2) EFFECTIVE DATE.—The repeals in paragraph (1) shall take effect on January 1, 2020.

(c) PROTECTING AMERICANS BY REPEAL OF DISCLOSURE AUTHORITY TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.—

(1) IN GENERAL.—Paragraph (21) of section 6103(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

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

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2020.

**SEC. 103. SMALL BUSINESS TAX CREDIT.**

(a) SUNSET.—

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

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

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

(b) DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT FOR PLAN WHICH INCLUDES COVERAGE FOR ABORTION.—

(1) IN GENERAL.—Subsection (h) of section 45R of the Internal Revenue Code of 1986 is amended—

(A) by striking ''Any term'' and inserting the following:

''(1) IN GENERAL.—Any term'', and

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

''(2) EXCLUSION OF HEALTH PLANS INCLUDING COVERAGE FOR ABORTION.—The term 'qualified health plan' does not include any health plan that includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).''.

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

**SEC. 104. INDIVIDUAL MANDATE.**

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

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

(2) in paragraph (3)—

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

(B) by striking subparagraph (D).

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

**SEC. 105. EMPLOYER MANDATE.**

(a) IN GENERAL.—

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

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

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

**SEC. 106. FEDERAL PAYMENTS TO STATES.**

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

(b) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

(B) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act in fiscal year 2014 made directly to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $1,000,000.

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

**SEC. 107. MEDICAID.**

The Social Security Act (42 U.S.C. 301 et seq.) is amended—

(1) in section 1902—

(A) in subsection (a)(10)(A), in each of clauses (i)(VIII) and (ii)(XX), by inserting ''and ending December 31, 2019,'' after ''January 1, 2014,''; and

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

(2) in section 1905—

(A) in the first sentence of subsection (b), by inserting ''(50 percent on or after January 1, 2020)'' after ''55 percent'';

(B) in subsection (y)(1), by striking the semicolon at the end of subparagraph (D) and all that follows through ''thereafter''; and

(C) in subsection (z)(2)—

(i) in subparagraph (A), by inserting ''through 2019'' after ''each year thereafter''; and

(ii) in subparagraph (B)(ii)(VI), by striking ''and each subsequent year'';

(3) in section 1915(k)(2), by striking ''during the period described in paragraph (1)'' and inserting ''on or after the date referred to in paragraph (1) and before January 1, 2020'';

(4) in section 1920(e), by adding at the end the following: ''This subsection shall not apply after December 31, 2019.'';

(5) in section 1937(b)(5), by adding at the end the following: ''This paragraph shall not apply after December 31, 2019.''; and

(6) in section 1943(a), by inserting ''and before January 1, 2020,'' after ''January 1, 2014,''.

**SEC. 108. REPEAL OF DSH ALLOTMENT REDUCTIONS.**

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

**SEC. 109. REPEAL OF THE TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS.**

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

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

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

**SEC. 110. REPEAL OF TAX ON OVER-THE-COUNTER MEDICATIONS.**

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

(b) ARCHER MSAs.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by striking ''Such term'' and all that follows through the period.

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

(d) EFFECTIVE DATES.—

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

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

**SEC. 111. REPEAL OF TAX ON HEALTH SAVINGS ACCOUNTS.**

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

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

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

**SEC. 112. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO FLEXIBLE SPENDING ACCOUNTS.**

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

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

**SEC. 113. REPEAL OF TAX ON PRESCRIPTION MEDICATIONS.**

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

''(j) REPEAL.—This section shall apply to calendar years beginning after December 31, 2010, and ending before January 1, 2018.''.

**SEC. 114. REPEAL OF MEDICAL DEVICE EXCISE TAX.**

Section 4191 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

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

**SEC. 115. REPEAL OF HEALTH INSURANCE TAX.**

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

**SEC. 116. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.**

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

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

**SEC. 117. REPEAL OF CHRONIC CARE TAX.**

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

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

**SEC. 118. REPEAL OF MEDICARE TAX INCREASE.**

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

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

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

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

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received after, and taxable years beginning after, December 31, 2017.

**SEC. 119. REPEAL OF TANNING TAX.**

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

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services performed after September 30, 2017.

**SEC. 120. REPEAL OF NET INVESTMENT TAX.**

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

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

**SEC. 121. REMUNERATION.**

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

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

**TITLE II**

**SEC. 201. THE PREVENTION AND PUBLIC HEALTH FUND.**

Subsection (b) of section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11) is amended—

(1) in paragraph (3), by striking ''each of fiscal years 2018 and 2019'' and inserting ''fiscal year 2018''; and

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

**SEC. 202. SUPPORT FOR STATE RESPONSE TO SUBSTANCE ABUSE PUBLIC HEALTH CRISIS AND URGENT MENTAL HEALTH NEEDS.**

(a) IN GENERAL.—There are authorized to be appropriated, and are appropriated, out of monies in the Treasury not otherwise obligated, $750,000,000 for each of fiscal years 2018 and 2019, to the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') to award grants to States to address the substance abuse public health crisis or to respond to urgent mental health needs within the State. In awarding grants under this section, the Secretary may give preference to States with an incidence or prevalence of substance use disorders that is substantial relative to other States or to States that identify mental health needs within their communities that are urgent relative to such needs of other States. Funds appropriated under this subsection shall remain available until expended.

(b) USE OF FUNDS.—Grants awarded to a State under subsection (a) shall be used for one or more of the following public health-related activities:

(1) Improving State prescription drug monitoring programs.

(2) Implementing prevention activities, and evaluating such activities to identify effective strategies to prevent substance abuse.

(3) Training for health care practitioners, such as best practices for prescribing opioids, pain management, recognizing potential cases of substance abuse, referral of patients to treatment programs, and overdose prevention.

(4) Supporting access to health care services provided by Federally certified opioid treatment programs or other appropriate health care providers to treat substance use disorders or mental health needs.

(5) Other public health-related activities, as the State determines appropriate, related to addressing the substance abuse public health crisis or responding to urgent mental health needs within the State.

**SEC. 203. COMMUNITY HEALTH CENTER PROGRAM.**

Effective as if included in the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10, 129 Stat. 87), paragraph (1) of section 221(a) of such Act is amended by inserting '', and an additional $422,000,000 for fiscal year 2017'' after ''2017''.

**SEC. 204. FUNDING FOR COST-SHARING PAYMENTS.**

There is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary for payments for cost-sharing reductions authorized by the Patient Protection and Affordable Care Act (including adjustments to any prior obligations for such payments) for the period beginning on the date of enactment of this Act and ending on December 31, 2019. Notwithstanding any other provision of this Act, payments and other actions for adjustments to any obligations incurred for

plan years 2018 and 2019 may be made through December 31, 2020.

**SEC. 205. REPEAL OF COST-SHARING SUBSIDY PROGRAM.**

(a) IN GENERAL.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is repealed.

(b) EFFECTIVE DATE.—The repeal made by subsection (a) shall apply to cost-sharing reductions (and payments to issuers for such reductions) for plan years beginning after December 31, 2019.

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**SA 272.** Mr. JOHNSON submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. _____. HEALTH INSURANCE COVERAGE FOR MEMBERS OF CONGRESS AND CONGRESSIONAL STAFF.**

(a) TREATMENT OF CONGRESSIONAL STAFF.—

(1) IN GENERAL.—Section 1312(d)(3)(D) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(d)(3)(D)) is amended—

(A) in clause (i)—

(i) in the matter preceding subclause (I)—

(I) by striking ''and congressional staff''; and

(II) by striking ''or congressional staff''; and

(ii) in subclause (II), by inserting ''to individuals'' before ''offered''; and

(B) by adding at the end the following:

''(iii) NO GOVERNMENT CONTRIBUTION.—For a Member of Congress enrolled in a health plan through an Exchange, there shall be no Government contribution under section 8906 of title 5, United States Code, or any other provision of law.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect with respect to plan years beginning on or after January 1, 2018.

(b) REGULATIONS.—The Director of the Office of Personnel Management shall update the regulations entitled, ''Federal Employees Health Benefits Program: Members of Congress and Congressional Staff'' (78 Fed. Reg. 60653), published on October 2, 2013, in accordance with the amendments made by subsection (a). The updated regulations shall provide that the Office of Personnel Management shall not offer a Small Business Health Options Program for Members of Congress;

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**SA 273.** Mr. JOHNSON submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

In lieu of the matter proposed to be inserted, insert the following:

**SECTION 1. SUNSET OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AND THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010.**

(a) PATIENT PROTECTION AND AFFORDABLE CARE ACT.—Effective with respect to plan years beginning on or after January 1, 2020, the Patient Protection and Affordable Care Act (Public Law 111–148), including the amendments made by such Act, shall have no force or effect.

(b) HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010.—Effective with respect to plan years beginning on or after January 1, 2020, the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), including the amendments made by such Act, shall have no force or effect.

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**SA 274.** Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

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

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

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

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

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

(2) in subparagraph (B), by striking ''determined by'' and all that follows through '' 'calendar year 2003'.'' and inserting ''determined by substituting 'calendar year 2003' for 'calendar year 1992' in subparagraph (B) thereof.''.

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

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**SA 275.** Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. _____. ALLOWING ALL INDIVIDUALS PURCHASING HEALTH INSURANCE IN THE INDIVIDUAL MARKET THE OPTION TO PURCHASE A LOWER PREMIUM CATASTROPHIC PLAN.**

(a) IN GENERAL.—Section 1302(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(e)) is amended by adding at the end the following:

''(4) CONSUMER FREEDOM.—For plan years beginning on or after January 1, 2019, paragraph (1)(A) shall not apply with respect to any plan offered in the State.''.

(b) RISK POOLS.—Section 1312(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(c)) is amended—

(1) in paragraph (1), by inserting ''and including, with respect to plan years beginning on or after January 1, 2019, enrollees in catastrophic plans described in section 1302(e)'' after ''Exchange''; and

(2) in paragraph (2), by inserting ''and including, with respect to plan years beginning on or after January 1, 2019, enrollees in catastrophic plans described in section 1302(e)'' after ''Exchange''.

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**SA 276.** Mr. KAINE (for himself, Mr. CARPER, Mr. COONS, Mrs. SHAHEEN, Mr. CARDIN, Ms. HASSAN, Ms. KLOBUCHAR, Ms. STABENOW, Mr. WARNER, Ms. HEITKAMP, and Mr. NELSON) submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

In lieu of the matter proposed to be inserted, insert the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Individual Health Insurance Marketplace Improvement Act''.

**SEC. 2. FINDINGS.**

Congress makes the following findings:

(1) Before the passage of the Patient Protection and Affordable Care Act (Public Law 114–148) in 2010, Americans with pre-existing conditions faced unfair barriers to accessing health insurance coverage and health care costs had risen rapidly for decades.

(2) Since 2010, the rate of uninsured Americans has declined to a historic low, with more than 20,000,000 Americans gaining access to health insurance coverage.

(3) Since 2010, America has experienced the slowest growth in the price of health care in over five decades.

(4) Thanks to the Patient Protection and Affordable Care Act (Public Law 114–148), Americans can no longer be denied insurance or charged more on the basis of their health status, more Americans than ever have insurance, and the health care they receive is continually improving.

(5) Starting in 2016, independent, non-partisan organizations, including the Congressional Budget Office, have determined that the individual health insurance markets have stabilized and improved.

(6) The cost-sharing reduction payments in the Patient Protection and Affordable Care Act provide stability in the individual health insurance market, lower insurance premiums by nearly 20 percent, and encourage competition among health insurers. The payments reduce costs for approximately 6,000,000 people with incomes below 250 percent of the poverty line by an average of about $1,100 per person and should be increased to help more Americans.

(7) Risk mitigation programs, such as the reinsurance program for the Medicare Part D prescription drug benefit program, have provided additional stability to the health insurance markets, restrained premium growth, and lowered taxpayer costs by helping health insurers predict and bear risk associated with managing health care costs for a population.

(8) From 2014 to 2016, the temporary reinsurance program established under the Affordable Care Act helped to stabilize the new insurance marketplaces and reduced insurance premiums in the individual health insurance market by as much as 10 percent.

(9) Throughout his Presidential campaign, the President of the United States repeatedly promised the American people that his health care plan will result in reduced rates of uninsured, lower costs, and higher quality care, stating on January 14, 2017, that ''We're going to have insurance for everybody. There was a philosophy in some circles that if you can't pay for it, you don't get it. That's not going to happen with us''; and on January 25, 2017, that ''I can assure you, we are going to have a better plan, much better health care, much better service treatment, a plan where you can have access to the doctor that you want and the plan that you want. We're

gonna have a much better health care plan at much less money''.

(10) The goal of any health care legislation should be to build on the Affordable Care Act to continue expanding coverage and make health care more affordable for Americans. Improving affordability and expanding coverage will also broaden the individual market risk pool, contributing to lower premiums and strengthening market stability.

**SEC. 3. SENSE OF THE SENATE.**

It is the sense of the Senate that, with the reinsurance program under section 4 bringing additional stability to the individual marketplace for the 2018 plan year, the Senate should work in a bipartisan manner to find solutions to improve the health care system.

**SEC. 4. INDIVIDUAL MARKET REINSURANCE FUND.**

(a) ESTABLISHMENT OF FUND.—

(1) IN GENERAL.—There is established the ''Individual Market Reinsurance Fund'' to be administered by the Secretary to provide funding for an individual market stabilization reinsurance program in each State that complies with the requirements of this section.

(2) FUNDING.—There is appropriated to the Fund, out of any moneys in the Treasury not otherwise appropriated, such sums as are necessary to carry out this section (other than subsection (c)) for each calendar year beginning with 2018. Amounts appropriated to the Fund shall remain available without fiscal or calendar year limitation to carry out this section.

(b) INDIVIDUAL MARKET REINSURANCE PROGRAM.—

(1) USE OF FUNDS.—The Secretary shall use amounts in the Fund to establish a reinsurance program under which the Secretary shall make reinsurance payments to health insurance issuers with respect to high-cost individuals enrolled in qualified health plans offered by such issuers that are not grandfathered health plans or transitional health plans for any plan year beginning with the 2018 plan year. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide payments from the Fund in accordance with this subsection.

(2) AMOUNT OF PAYMENT.—The payment made to a health insurance issuer under subsection (a) with respect to each high-cost individual enrolled in a qualified health plan issued by the issuer that is not a grandfathered health plan or a transitional health plan shall equal 80 percent of the lesser of—

(A) the amount (if any) by which the individual's claims incurred during the plan year exceeds—

(i) in the case of the 2018, 2019, or 2020 plan year, $50,000; and

(ii) in the case of any other plan year, $100,000; or

(B) for plan years described in—

(i) subparagraph (A)(i), $450,000; and

(ii) subparagraph (A)(ii), $400,000.

(3) INDEXING.—In the case of plan years beginning after 2018, the dollar amounts that appear in subparagraphs (A) and (B) of paragraph (2) shall each be increased by an amount equal to—

(A) such amount; multiplied by

(B) the premium adjustment percentage specified under section 1302(c)(4) of the Affordable Care Act, but determined by substituting ''2018'' for ''2013''.

(4) PAYMENT METHODS.—

(A) IN GENERAL.—Payments under this subsection shall be based on such a method as the Secretary determines. The Secretary may establish a payment method by which interim payments of amounts under this subsection are made during a plan year based on the Secretary's best estimate of amounts that will be payable after obtaining all of the information.

(B) REQUIREMENT FOR PROVISION OF INFORMATION.—

(i) REQUIREMENT.—Payments under this subsection to a health insurance issuer are conditioned upon the furnishing to the Secretary, in a form and manner specified by the Secretary, of such information as may be required to carry out this subsection.

(ii) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to clause (i) is subject to the HIPAA privacy and security law, as defined in section 3009(a) of the Public Health Service Act (42 U.S.C. 300jj–19(a)).

(5) SECRETARY FLEXIBILITY FOR BUDGET NEUTRAL REVISIONS TO REINSURANCE PAYMENT SPECIFICATIONS.—If the Secretary determines appropriate, the Secretary may substitute higher dollar amounts for the dollar amounts specified under subparagraphs (A) and (B) of paragraph (2) (and adjusted under paragraph (3), if applicable) if the Secretary certifies that such substitutions, considered together, neither increase nor decease the total projected payments under this subsection.

(c) OUTREACH AND ENROLLMENT.—

(1) IN GENERAL.—During the period that begins on January 1, 2018, and ends on December 31, 2020, the Secretary shall award grants to eligible entities for the following purposes:

(A) OUTREACH AND ENROLLMENT.—To carry out outreach, public education activities, and enrollment activities to raise awareness of the availability of, and encourage enrollment in, qualified health plans.

(B) ASSISTING INDIVIDUALS TRANSITION TO QUALIFIED HEALTH PLANS.—To provide assistance to individuals who are enrolled in health insurance coverage that is not a qualified health plan enroll in a qualified health plan.

(C) ASSISTING ENROLLMENT IN PUBLIC HEALTH PROGRAMS.—To facilitate the enrollment of eligible individuals in the Medicare program or in a State Medicaid program, as appropriate.

(D) RAISING AWARENESS OF PREMIUM ASSISTANCE AND COST-SHARING REDUCTIONS.—To distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium assistance tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act, and to assist eligible individuals in applying for such tax credits and cost-sharing reductions.

(2) ELIGIBLE ENTITIES DEFINED.—

(A) IN GENERAL.—In this subsection, the term ''eligible entity'' means—

(i) a State; or

(ii) a nonprofit community-based organization.

(B) ENROLLMENT AGENTS.—Such term includes a licensed independent insurance agent or broker that has an arrangement with a State or nonprofit community-based organization to enroll eligible individuals in qualified health plans.

(C) EXCLUSIONS.—Such term does not include an entity that—

(i) is a health insurance issuer; or

(ii) receives any consideration, either directly or indirectly, from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

(3) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to awarding grants to States or eligible entities in States that have geographic rating areas at risk of having no qualified health plans in the individual market.

(4) FUNDING.—Out of any moneys in the Treasury not otherwise appropriated, $500,000,000 is appropriated to the Secretary for each of calendar years 2018 through 2020, to carry out this subsection.

(d) REPORTS TO CONGRESS.—

(1) ANNUAL REPORT.—The Secretary shall submit a report to Congress, not later than January 21, 2019, and each year thereafter, that contains the following information for the most recently ended year:

(A) The number and types of plans in each State's individual market, specifying the number that are qualified health plans, grandfathered health plans, or health insurance coverage that is not a qualified health plan.

(B) The impact of the reinsurance payments provided under this section on the availability of coverage, cost of coverage, and coverage options in each State.

(C) The amount of premiums paid by individuals in each State by age, family size, geographic area in the State's individual market, and category of health plan (as described in subparagraph (A)).

(D) The process used to award funds for outreach and enrollment activities awarded to eligible entities under subsection (c), the amount of such funds awarded, and the activities carried out with such funds.

(E) Such other information as the Secretary deems relevant.

(2) EVALUATION REPORT.—Not later than January 31, 2022, the Secretary shall submit to Congress a report that—

(A) analyzes the impact of the funds provided under this section on premiums and enrollment in the individual market in all States; and

(B) contains a State-by-State comparison of the design of the programs carried out by States with funds provided under this section.

(e) DEFINITIONS.—In this section:

(1) SECRETARY.—The term ''Secretary'' means the Secretary of the Department of Health and Human Services.

(2) FUND.—The term ''Fund'' means the Individual Market Reinsurance Fund established under subsection (a).

(3) GRANDFATHERED HEALTH PLAN.—The term ''grandfathered health plan'' has the meaning given that term in section 1251(e) of the Patient Protection and Affordable Care Act.

(4) HIGH-COST INDIVIDUAL.—The term ''high-cost individual'' means an individual enrolled in a qualified health plan (other than a grandfathered health plan or a transitional health plan) who incurs claims in excess of $50,000 during a plan year.

(5) STATE.—The term ''State'' means each of the 50 States and the District of Columbia.

(6) TRANSITIONAL HEALTH PLAN.—The term ''transitional health plan'' means a plan continued under the letter issued by the Centers for Medicare & Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for coverage in the individual and small group markets to which section 1251 of the Patient Protection and Affordable Care Act does not apply, and under the extension of the transitional policy for such coverage set forth in the Insurance Standards Bulletin Series guidance issued by the Centers for Medicare & Medicaid Services on March 5, 2014, February 29, 2016, and February 13, 2017.

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**SA 277.** Mr. KAINE submitted an amendment intended to be proposed by him to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department

of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle E of title XXVIII, add the following:

**SEC. 2850. ESTABLISHMENT OF A VISITOR SERVICES FACILITY ON THE ARLINGTON RIDGE TRACT.**

(a) ARLINGTON RIDGE TRACT DEFINED.—In this section, the term ''Arlington Ridge tract'' means the parcel of Federal land located in Arlington County, Virginia, known as the ''Nevius Tract'' and transferred to the Department of the Interior in 1953, that is bounded generally by—

(1) Arlington Boulevard (United States Route 50) to the north;

(2) Jefferson Davis Highway (Virginia Route 110) to the east;

(3) Marshall Drive to the south; and

(4) North Meade Street to the west.

(b) ESTABLISHMENT OF VISITOR SERVICES FACILITY.—Notwithstanding section 2863(g) of the Military Construction Authorization Act for Fiscal Year 2002 (Public Law 107–107; 115 Stat. 1332), the Secretary of the Interior may construct a structure for visitor services, including a public restroom facility, on the Arlington Ridge tract in the area of the United States Marine Corps War Memorial.

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**SA 278.** Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle J of title VIII, add the following:

**SEC. 899D. INCLUSION OF SBIR AND STTR PROGRAMS IN TECHNICAL ASSISTANCE.**

Section 2418(c) of title 10, United States Code, is amended—

(1) by striking ''issued under'' and inserting the following: ''issued—

''(1) under'';

(2) by striking ''and on'' and inserting '', and on'';

(3) by striking ''requirements.'' and inserting ''requirements; and''; and

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

''(2) under section 9 of the Small Business Act (15 U.S.C. 638), and on compliance with those requirements.''.

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**SA 279.** Mr. PAUL submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. PROTECTION OF SECOND AMENDMENT RIGHTS.**

(a) ENSURING THE QUALITY OF CARE.—Section 2717(c) of the Public Health Service Act (42 U.S.C. 300gg–17(c)) is amended by inserting '', or the Better Care Reconciliation Act of 2017 or an amendment made by that Act,'' after ''the Patient Protection and Affordable Care Act or an amendment made by that Act'' each place that term appears.

(b) FEDERAL HEALTH DATABASES; NICS.—No funds made available to the Department of Health and Human Services or any other agency under this Act may be used to examine a Federal health database for the name of an individual to be submitted to the National Instant Criminal Background Check System (commonly known as ''NICS'') established under section 103 of the Brady Handgun Violence Prevention Act (18 U.S.C. 922 note).

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**SA 280.** Mr. PAUL submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Obamacare Repeal Reconciliation Act of 2017''.

**TITLE I**

**SEC. 101. RECAPTURE EXCESS ADVANCE PAYMENTS OF PREMIUM TAX CREDITS.**

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

''(iii) NONAPPLICABILITY OF LIMITATION.—This subparagraph shall not apply to taxable years ending after December 31, 2017, and before January 1, 2020.''.

**SEC. 102. PREMIUM TAX CREDIT.**

(a) PREMIUM TAX CREDIT.—

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

(A) IN GENERAL.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986 is amended by inserting before the period at the end the following: ''or a plan that includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest)''.

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

(2) REPEAL.—

(A) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking section 36B.

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

(b) REPEAL OF ELIGIBILITY DETERMINATIONS.—

(1) IN GENERAL.—The following sections of the Patient Protection and Affordable Care Act are repealed:

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

(B) Section 1412.

(2) EFFECTIVE DATE.—The repeals in paragraph (1) shall take effect on January 1, 2020.

(c) PROTECTING AMERICANS BY REPEAL OF DISCLOSURE AUTHORITY TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.—

(1) IN GENERAL.—Paragraph (21) of section 6103(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

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

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2020.

**SEC. 103. SMALL BUSINESS TAX CREDIT.**

(a) SUNSET.—

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

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

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

(b) DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT FOR PLAN WHICH INCLUDES COVERAGE FOR ABORTION.—

(1) IN GENERAL.—Subsection (h) of section 45R of the Internal Revenue Code of 1986 is amended—

(A) by striking ''Any term'' and inserting the following:

''(1) IN GENERAL.—Any term'', and

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

''(2) EXCLUSION OF HEALTH PLANS INCLUDING COVERAGE FOR ABORTION.—The term 'qualified health plan' does not include any health plan that includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).''.

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

**SEC. 104. INDIVIDUAL MANDATE.**

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

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

(2) in paragraph (3)—

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

(B) by striking subparagraph (D).

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

**SEC. 105. EMPLOYER MANDATE.**

(a) IN GENERAL.—

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

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

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

**SEC. 106. FEDERAL PAYMENTS TO STATES.**

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

(b) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

(B) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act in fiscal year 2014 made directly to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $1,000,000.

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

**SEC. 107. MEDICAID.**

The Social Security Act (42 U.S.C. 301 et seq.) is amended—

(1) in section 1902—

(A) in subsection (a)(10)(A), in each of clauses (i)(VIII) and (ii)(XX), by inserting ''and ending December 31, 2019,'' after ''January 1, 2014,''; and

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

(2) in section 1905—

(A) in the first sentence of subsection (b), by inserting ''(50 percent on or after January 1, 2020)'' after ''55 percent'';

(B) in subsection (y)(1), by striking the semicolon at the end of subparagraph (D) and all that follows through ''thereafter''; and

(C) in subsection (z)(2)—

(i) in subparagraph (A), by inserting ''through 2019'' after ''each year thereafter''; and

(ii) in subparagraph (B)(ii)(VI), by striking ''and each subsequent year'';

(3) in section 1915(k)(2), by striking ''during the period described in paragraph (1)'' and inserting ''on or after the date referred to in paragraph (1) and before January 1, 2020'';

(4) in section 1920(e), by adding at the end the following: ''This subsection shall not apply after December 31, 2019.'';

(5) in section 1937(b)(5), by adding at the end the following: ''This paragraph shall not apply after December 31, 2019.''; and

(6) in section 1943(a), by inserting ''and before January 1, 2020,'' after ''January 1, 2014,''.

**SEC. 108. REPEAL OF DSH ALLOTMENT REDUCTIONS.**

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

**SEC. 109. REPEAL OF THE TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS.**

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

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

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

**SEC. 110. REPEAL OF TAX ON OVER-THE-COUNTER MEDICATIONS.**

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

(b) ARCHER MSAs.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by striking ''Such term'' and all that follows through the period.

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

(d) EFFECTIVE DATES.—

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

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

**SEC. 111. REPEAL OF TAX ON HEALTH SAVINGS ACCOUNTS.**

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

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

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

**SEC. 112. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO FLEXIBLE SPENDING ACCOUNTS.**

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

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

**SEC. 113. REPEAL OF TAX ON PRESCRIPTION MEDICATIONS.**

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

''(j) REPEAL.—This section shall apply to calendar years beginning after December 31, 2010, and ending before January 1, 2018.''.

**SEC. 114. REPEAL OF MEDICAL DEVICE EXCISE TAX.**

Section 4191 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

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

**SEC. 115. REPEAL OF HEALTH INSURANCE TAX.**

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

**SEC. 116. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.**

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

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

**SEC. 117. REPEAL OF CHRONIC CARE TAX.**

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

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

**SEC. 118. REPEAL OF MEDICARE TAX INCREASE.**

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

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

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

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

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received after, and taxable years beginning after, December 31, 2017.

**SEC. 119. REPEAL OF TANNING TAX.**

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

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services performed after September 30, 2017.

**SEC. 120. REPEAL OF NET INVESTMENT TAX.**

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

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

**SEC. 121. REMUNERATION.**

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

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

## TITLE II

**SEC. 201. THE PREVENTION AND PUBLIC HEALTH FUND.**

Subsection (b) of section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11) is amended—

(1) in paragraph (3), by striking ''each of fiscal years 2018 and 2019'' and inserting ''fiscal year 2018''; and

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

**SEC. 202. SUPPORT FOR STATE RESPONSE TO SUBSTANCE ABUSE PUBLIC HEALTH CRISIS AND URGENT MENTAL HEALTH NEEDS.**

(a) IN GENERAL.—There are authorized to be appropriated, and are appropriated, out of monies in the Treasury not otherwise obligated, $750,000,000 for each of fiscal years 2018 and 2019, to the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') to award grants to States to address the substance abuse public health crisis or to respond to urgent mental health needs within the State. In awarding grants under this section, the Secretary may give preference to States with an incidence or prevalence of substance use disorders that is substantial relative to other States or to States that identify mental health needs within their communities that are urgent relative to such needs of other States. Funds

appropriated under this subsection shall remain available until expended.

(b) USE OF FUNDS.—Grants awarded to a State under subsection (a) shall be used for one or more of the following public health-related activities:

(1) Improving State prescription drug monitoring programs.

(2) Implementing prevention activities, and evaluating such activities to identify effective strategies to prevent substance abuse.

(3) Training for health care practitioners, such as best practices for prescribing opioids, pain management, recognizing potential cases of substance abuse, referral of patients to treatment programs, and overdose prevention.

(4) Supporting access to health care services provided by Federally certified opioid treatment programs or other appropriate health care providers to treat substance use disorders or mental health needs.

(5) Other public health-related activities, as the State determines appropriate, related to addressing the substance abuse public health crisis or responding to urgent mental health needs within the State.

**SEC. 203. COMMUNITY HEALTH CENTER PROGRAM.**

Effective as if included in the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10, 129 Stat. 87), paragraph (1) of section 221(a) of such Act is amended by inserting '', and an additional $422,000,000 for fiscal year 2017'' after ''2017''.

**SEC. 204. FUNDING FOR COST-SHARING PAYMENTS.**

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

**SEC. 205. REPEAL OF COST-SHARING SUBSIDY PROGRAM.**

(a) IN GENERAL.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is repealed.

(b) EFFECTIVE DATE.—The repeal made by subsection (a) shall apply to cost-sharing reductions (and payments to issuers for such reductions) for plan years beginning after December 31, 2019.

## AUTHORITY FOR COMMITTEES TO MEET

Mr. ENZI. Mr. President, I have 7 requests for committees to meet during today's session of the Senate. They have the approval of the Majority and Minority leaders.

Pursuant to rule XXVI, paragraph 5(a), of the Standing Rules of the Senate, the following committees are authorized to meet during today's session of the Senate:

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

The Committee on Agriculture, Nutrition, and Forestry is authorized to meet during the session of the Senate on Tuesday, July 25, 2017 at 8:30 am, in 106 Dirksen Senate Office Building, in order to conduct a hearing entitled ''Commodities, Credit, and Crop Insurance: Perspectives on Risk Management Tools and Trends for the 2018 Farm Bill.''

COMMITTEE ON THE JUDICIARY

The Committee on the Judiciary is authorized to meet during the session of the Senate on July 25, 2017, at 10 a.m., in room SD–226 of the Dirksen Senate Office Building, to conduct a hearing entitled ''Nominations.''

COMMITTEE ON INTELLIGENCE

The Senate Select Committee on Intelligence is authorized to meet during the session of the 115th Congress of the U.S. Senate on Tuesday, July 25, 2017 from 2:30 pm, in room SH–219 of the Senate Hart Office Building to hold a Closed Business Meeting followed by a Closed Member Briefing.

SUBCOMMITTEE ON SEAPOWER

The Subcommittee on Seapower of the Committee on Armed Services is authorized to meet during the session of the Senate on Tuesday, July 25, 2017, at 2:30 p.m., in open session, to receive testimony on options and considerations for achieving a 355-ship Navy from naval analysts.

SUBCOMMITTEE ON OCEAN, ATMOSPHERE, FISHERIES, AND COAST GUARD

The Committee on Commerce, Science, and Transportation is authorized to hold a meeting during the session of the Senate on Tuesday, July 25, 2017, at 10 AM in room 253 of the Russell Senate Office Building. The Committee will hold Subcommittee Hearing on ''Efforts on Marine Debris in the Oceans and Great Lakes.''

SUBCOMMITTEE ON CLEAN AIR AND NUCLEAR SAFETY

The Subcommittee on Clean air and Nuclear Safety of the Committee on Environment and Public Works be authorized to meet during the session of the Senate on Tuesday, July 25, 2017, at 10 AM, in Room 406 of the Dirksen Senate office building, to conduct a hearing entitled, ''Developing and Deploying Advanced Clean Energy Technologies.''

SUBCOMMITTEE ON EAST ASIA, THE PACIFIC, AND INTERNATIONAL CYBER SECURITY POLICY

The Committee on Foreign Relations Subcommittee on East Asia, the Pacific, and International Cyber Security Policy is authorized to meet during the session of the Senate on Tuesday, July 25, 2017 at 2:30 p.m., to hold a hearing entitled ''Assessing the Maximum Pressure and Engagement Policy toward North Korea.''

## PRIVILEGES OF THE FLOOR

Mr. ENZI. Mr. President, I ask unanimous consent that Paul Vinovich and Greg D'Angelo, from my staff, be given all-access floor passes to the Senate floor and that Robert Creager, Tiffany Mortimore, Sean Ross, and Sam Safari, interns for the Budget Committee, be granted floor privileges during the consideration of H.R. 1628.

The PRESIDING OFFICER. Without objection, it is so ordered.

## ORDERS FOR WEDNESDAY, JULY 26, 2017

Mr. ENZI. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:30 a.m., Wednesday, July 26; that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and morning business be closed; further, that following leader remarks, the Senate resume consideration of H.R. 1628, with the time until 11:30 a.m. equally divided between the two leaders or their designees; finally, that the previous order with respect to the vote time in relation to amendment No. 271 be modified to occur at 11:30 a.m. tomorrow, and the vote on the pending motion to commit occur at 3:30 p.m. tomorrow, with all other provisions remaining in effect.

The PRESIDING OFFICER. Without objection, it is so ordered.

## ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. ENZI. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that it stand adjourned under the previous order.

There being no objection, the Senate, at 9:58 p.m., adjourned until Wednesday, July 26, 2017, at 9:30 a.m.

## NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF AGRICULTURE

SAMUEL H. CLOVIS, JR., OF IOWA, TO BE UNDER SECRETARY OF AGRICULTURE FOR RESEARCH, EDUCATION, AND ECONOMICS, VICE CATHERINE E. WOTEKI.

DEPARTMENT OF DEFENSE

MARK T. ESPER, OF VIRGINIA, TO BE SECRETARY OF THE ARMY, VICE ERIC K. FANNING.

ANTHONY KURTA, OF MONTANA, TO BE A PRINCIPAL DEPUTY UNDER SECRETARY OF DEFENSE, VICE LAURA JUNOR, RESIGNED.

ROBERT L. WILKIE, OF NORTH CAROLINA, TO BE UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, VICE JESSICA GARFOLA WRIGHT, RESIGNED.

DEPARTMENT OF THE INTERIOR

JOSEPH BALASH, OF ALASKA, TO BE AN ASSISTANT SECRETARY OF THE INTERIOR, VICE JANICE MARION SCHNEIDER.

DEPARTMENT OF STATE

KATHLEEN M. FITZPATRICK, OF THE DISTRICT OF COLUMBIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER–COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE DEMOCRATIC REPUBLIC OF TIMOR–LESTE.

A. WESS MITCHELL, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF STATE (EUROPEAN AND EURASIAN AFFAIRS), VICE VICTORIA NULAND.

DEPARTMENT OF HOMELAND SECURITY

DANIEL ALAN CRAIG, OF MARYLAND, TO BE DEPUTY ADMINISTRATOR, FEDERAL EMERGENCY MANAGEMENT AGENCY, DEPARTMENT OF HOMELAND SECURITY, VICE JOSEPH L. NIMMICH.

IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

*To be lieutenant general*

LT. GEN. ROBERT P. ASHLEY, JR.

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE RESERVE OF THE ARMY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

*To be major general*

BRIG. GEN. DARRELL J. GUTHRIE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE RESERVE OF THE ARMY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

*To be brigadier general*

COL. BRIAN E. MILLER

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

*To be lieutenant commander*

CLAIR E. SMITH

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

*To be lieutenant commander*

MORGAN E. MCCLELLAN

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE GRADE INDICATED IN THE REGULAR NAVY UNDER TITLE 10, U.S.C., SECTION 531:

*To be lieutenant commander*

ANDREW B. BRIDGFORTH
RONALD J. MITCHELL