

115TH CONGRESS
1ST SESSION

S. 191

To improve patient choice by allowing States to adopt market-based alternatives to the Affordable Care Act that increase access to affordable health insurance and reduce costs while ensuring important consumer protections and improving patient care.

IN THE SENATE OF THE UNITED STATES

JANUARY 23, 2017

Mr. CASSIDY (for himself, Ms. COLLINS, Mrs. CAPITO, and Mr. ISAKSON) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To improve patient choice by allowing States to adopt market-based alternatives to the Affordable Care Act that increase access to affordable health insurance and reduce costs while ensuring important consumer protections and improving patient care.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Patient Freedom Act of 2017”.

6 (b) TABLE OF CONTENTS.—The table of contents for
7 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—HEALTH REFORM

Sec. 100. Definitions.

Subtitle A—Insurance Market Reform

Sec. 101. Ending the “one size fits all” ACA approach; continuing consumer protection policies by covering adult children, protecting individuals with preexisting conditions, and not applying lifetime or annual limits.

Sec. 102. State health insurance options.

Sec. 103. State alternative option.

Sec. 104. Computation of monthly Roth HSA deposit amount for deposit qualifying residents.

Sec. 105. State options for improved access to health insurance coverage in each State.

Sec. 106. State flexibility in ensuring orderly health insurance market outside of an Exchange.

Sec. 107. Expanded access and patient protections.

Sec. 108. Application of health savings accounts in relation to Medicaid.

Subtitle B—Provider Price Transparency

Sec. 121. Ensuring access to emergency services without excessive charges for out-of-network services.

TITLE II—REFORM OF TAX PROVISIONS RELATING TO HEALTH CARE

Subtitle A—Health Savings Accounts

Sec. 201. Transition to non-deductible HSAs.

Sec. 202. Treatment of direct primary care.

Sec. 203. Treatment of HSA after death of account beneficiary.

Subtitle B—Health Care Tax Credits

Sec. 211. Limited application of PPACA health premium credit.

Sec. 212. New Roth HSA credit.

1 **TITLE I—HEALTH REFORM**

2 **SEC. 100. DEFINITIONS.**

3 In this title:

4 (1) **PATIENT-GRANT ELECTING STATE.**—The
 5 term “patient-grant electing State” means an elect-
 6 ing State that specifies under section 103(a)(3)(B)
 7 that it will carry out section 103(b) itself (and not

1 to have section 103(b) carried out by means of the
 2 credit under section 36C of the Internal Revenue
 3 Code of 1986).

4 (2) BUDGET NEUTRAL.—The term “budget
 5 neutral” with respect to expenditures provided for in
 6 this Act, means the same amount of expenditures as
 7 are provided for under the Patient Protection and
 8 Affordable Care Act (Public Law 111–148).

9 (3) CHIP.—The term “CHIP” means the Chil-
 10 dren’s Health Insurance Program established under
 11 title XXI of the Social Security Act (42 U.S.C. 1396
 12 et seq.).

13 (4) CREDITABLE COVERAGE.—The term “cred-
 14 itable coverage” has the meaning given such term in
 15 section 2704(c)(1) of the Public Health Service Act
 16 (42 U.S.C. 300gg–3(c)(1)), as in effect as of the day
 17 before the date of the enactment of this Act.

18 (5) DEFAULT HEALTH INSURANCE COV-
 19 ERAGE.—The term “default health insurance cov-
 20 erage” has the meaning given such term in section
 21 107(c)(2).

22 (6) DEPOSIT QUALIFYING RESIDENT.—The
 23 term “deposit qualifying resident” has the meaning
 24 given such term in section 103(b)(2).

1 (7) ELECTING STATE.—The term “electing
2 State” means a State that elects under section
3 102(a)(2) the alternative option described in section
4 103.

5 (8) HEALTH INSURANCE COVERAGE.—The term
6 “health insurance coverage” has the meaning given
7 such term in section 2791(b)(1) of the Public Health
8 Service Act (42 U.S.C. 300gg–91(b)(1)).

9 (9) HEALTH SAVINGS DEPOSIT.—The term
10 “health savings deposit” means a deposit made into
11 a Roth HSA pursuant to section 103.

12 (10) MEDICAID.—The term “Medicaid” means
13 the program under title XIX of the Social Security
14 Act (42 U.S.C. 1396 et seq.).

15 (11) MEDICARE.—The term “Medicare” means
16 the program under part A or B of title XVIII of the
17 Social Security Act (42 U.S.C. 1395 et seq.).

18 (12) PPACA.—The term “PPACA” means the
19 Patient Protection and Affordable Care Act (Public
20 Law 111–148), as in effect on the day before the
21 date of the enactment of this Act, unless otherwise
22 specified.

23 (13) QUALIFIED HEALTH PLAN COVERAGE.—
24 The term “qualified health plan coverage” means,
25 with respect to residents of a State, health insurance

1 coverage that meets applicable standards under
 2 State law, which standards need not be the same as
 3 that previously required of qualified health plans
 4 under title I of PPACA, and includes a high deduct-
 5 ible health plan (as defined in section 223(c)(2) of
 6 the Internal Revenue Code of 1986) and includes
 7 coverage under a group health plan.

8 (14) QUALIFIED RESIDENT.—The term “quali-
 9 fied resident” means, with respect to a State for a
 10 month, an individual who is a resident of the State
 11 as of the first day of the month and is a citizen or
 12 national of the United States or otherwise lawfully
 13 residing in the State under color of law.

14 (15) ROTH HEALTH SAVINGS ACCOUNT; ROTH
 15 HSA.—The terms “Roth health savings account” and
 16 “Roth HSA” mean a Roth HSA established under
 17 section 530A of the Internal Revenue Code of 1986.

18 (16) SECRETARY.—The term “Secretary”
 19 means the Secretary of Health and Human Services.

20 (17) STATE.—The term “State” means the 50
 21 States and the District of Columbia.

22 (18) UNINSURED.—The term “uninsured”
 23 means, with respect to an individual, that the indi-
 24 vidual does not have creditable coverage.

Subtitle A—Insurance Market Reform

SEC. 101. ENDING THE “ONE SIZE FITS ALL” ACA APPROACH; CONTINUING CONSUMER PROTECTION POLICIES BY COVERING ADULT CHILDREN, PROTECTING INDIVIDUALS WITH PREEXISTING CONDITIONS, AND NOT APPLYING LIFETIME OR ANNUAL LIMITS.

(a) IN GENERAL.—Subject to subsections (b) and (c), title I of the Patient Protection and Affordable Care Act (including the amendments made by such title) shall not apply (and the provisions of law amended by such title are restored as if such title had not been enacted) in the case of any State that does not have in effect the election described in section 102(a)(1).

(b) CONTINUATION OF POLICIES FOR EXTENSION OF DEPENDENT COVERAGE FOR ADULT CHILDREN AND PROHIBITION OF LIFETIME AND ANNUAL COVERAGE LIMITS; PRESERVATION OF BLACK LUNG BENEFITS.—

(1) PUBLIC HEALTH SERVICE ACT PROVISIONS.—Notwithstanding subsection (a), the following sections of the Public Health Service Act, that were added or amended by subtitles A and C of title I of PPACA, shall continue to apply to group

1 health plans and to health insurance coverage of-
 2 fered in the individual and group market:

3 (A) NO LIFETIME OR ANNUAL LIMITS.—
 4 Section 2711 (relating to no lifetime or annual
 5 limits), except in the case of limited benefit in-
 6 surance.

7 (B) DEPENDENT COVERAGE THROUGH
 8 AGE 26.—Section 2714 (relating to extension of
 9 dependent coverage).

10 (C) PROHIBITING PRE-EXISTING CONDI-
 11 TION EXCLUSIONS.—Section 2704 (relating to
 12 prohibition on preexisting conditions).

13 (D) PROHIBITING DISCRIMINATION BASED
 14 ON HEALTH STATUS.—Section 2705 (relating to
 15 prohibiting discrimination against individual
 16 participants and beneficiaries based on health
 17 status), subject to subsection (c).

18 (E) PRESERVATION OF PREVENTIVE SERV-
 19 ICE COVERAGE.—Section 2713 (relating to cov-
 20 erage of preventive health services), if employ-
 21 ers do not contribute to the individual's Roth
 22 HSA.

23 (2) PRESERVATION OF NON-DISCRIMINATION IN
 24 HEALTH CARE.—Subsection (a) shall not apply with

1 respect to section 1557 of title I of the Patient Pro-
 2 tection and Affordable Care Act (42 U.S.C. 18116).

3 (3) PRESERVATION OF COVERAGE OF MENTAL
 4 HEALTH SERVICES, AND APPLICABILITY OF MENTAL
 5 HEALTH PARITY.—For serious mental illness, seri-
 6 ous emotional disturbance, and substance use dis-
 7 order, subsection (a) shall not apply with respect to
 8 section 1302(b)(1)(E) of title I of the Patient Pro-
 9 tection and Affordable Care Act (relating to cov-
 10 erage of mental health and substance use treatment
 11 at limited cost sharing) (42 U.S.C. 18022(b)(1)(E)).
 12 Section 2726 of the Public Health Service Act shall
 13 apply to qualified health plans in the same manner
 14 and to the same extent as such section applies to
 15 health insurance coverage and group health plans.

16 (4) PRESERVATION OF BLACK LUNG BENEFITS
 17 FOR COAL MINERS.—Subsection (a) shall not apply
 18 with respect to section 1556 of title I of the Patient
 19 Protection and Affordable Care Act (amending the
 20 Black Lung Benefits Act).

21 (5) PRESERVATION OF STATE INNOVATIONS.—
 22 Subsection (a) shall not apply with respect to section
 23 1332 of title I of the Patient Protection and Afford-
 24 able Care Act (42 U.S.C. 18052).

1 (c) CONTINUATION OF FEDERAL EXCHANGES.—Sub-
 2 section (a) shall not apply with respect to Federal Ex-
 3 changes established pursuant to section 1321(c) of the Pa-
 4 tient Protection and Affordable Care Act (42 U.S.C.
 5 18041(c)) and such Exchanges shall continue to operate
 6 as provided for by the Secretary.

7 **SEC. 102. STATE HEALTH INSURANCE OPTIONS.**

8 (a) IN GENERAL.—Each State may elect, through
 9 written notice to the Secretary after the date of the enact-
 10 ment of this Act and in accordance with this title, 1 of
 11 the following 3 options in relation to the implementation
 12 of title I of the Patient Protection and Affordable Care
 13 Act after the date of enactment of this Act:

14 (1) CONTINUING IMPLEMENTATION OF
 15 PPACA.—The State continuing—

16 (A) the Federal premium and cost-sharing
 17 subsidies for coverage offered under title I of
 18 PPACA (and the amendments made thereby),
 19 reduced for qualified residents of such State for
 20 any year by the amount (if any) by which such
 21 subsidies would exceed the amount of contribu-
 22 tions that would have been made under section
 23 103(b) to all such residents for such year if the
 24 State had elected the option under paragraph
 25 (3); and

1 (B) all other requirements under such title.

2 (2) ESTABLISHING NEW STATE AND MARKET-
3 BASED ALTERNATIVE, WITH ALTERNATIVE PER BEN-
4 EFICIARY FEDERAL DEPOSIT SYSTEM.—The State
5 implementing the alternative option described in sec-
6 tion 103, which includes—

7 (A) the waiver of most requirements im-
8 posed under such title I; and

9 (B) the provision of a new, Roth HSA- and
10 market-based deposit system for individuals
11 who do not otherwise qualify for Federal or
12 State subsidies for health benefits coverage.

13 (3) REJECTION OF PPACA.—The State rejecting
14 title I of PPACA (and the amendments made there-
15 by), except as otherwise required in this title.

16 If a State fails to make an election described in this sub-
17 section during the 1-year period beginning on the date of
18 enactment of this Act, the State shall be deemed to have
19 made the election described in paragraph (2). A State
20 may, through written notice to the Secretary, change an
21 election previously made under this subsection.

22 (b) RELATION TO CURRENT MEDICAID ACA COV-
23 ERAGE OPTION.—Nothing in this section shall be con-
24 strued to change the option of a State with respect to the
25 implementation of Medicaid ACA coverage under section

1 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42
 2 U.S.C. 1396a(a)(10)(A)(i)(VIII)), except that a State that
 3 elects not to provide medical assistance to individuals
 4 under such section may make such individuals deposit
 5 qualifying residents under this title.

6 **SEC. 103. STATE ALTERNATIVE OPTION.**

7 (a) IN GENERAL.—In the case of a State that elects
 8 under section 102(a)(2) the alternative option under this
 9 section, subject to subsection (d) and section 107, the fol-
 10 lowing shall apply:

11 (1) ELIMINATION OF INDIVIDUAL AND EM-
 12 PLOYER SHARED RESPONSIBILITY FOR HEALTH
 13 CARE TAX REQUIREMENTS FOR RESIDENTS AND EM-
 14 PLOYEES IN STATE.—The individual and employer
 15 health care responsibilities under the amendments
 16 made by title I of PPACA (including under sections
 17 5000A and 4980H of the Internal Revenue Code of
 18 1986) shall no longer apply pursuant to section 101
 19 with respect to individuals who are residents of such
 20 State and with respect to individuals who are em-
 21 ployed in such State, respectively.

22 (2) MODIFICATION OF INSURANCE REQUIRE-
 23 MENTS.—Except as specifically provided in this title,
 24 the requirements under title I of PPACA (including
 25 amendments made by such title) relating to health

1 insurance coverage offered in the State shall not
2 apply except to the extent specified by the State.

3 (3) NEW DEPOSIT SYSTEM THROUGH FUNDING
4 ROTH HSAS.—

5 (A) IN GENERAL.—Deposit qualifying resi-
6 dents (as defined in subsection (b)(2)) who are
7 residing in the State are eligible for a deposit
8 to a Roth HSA that may be used for premiums
9 and cost-sharing for health insurance coverage
10 in accordance with subsection (b).

11 (B) STATE SPECIFICATION OF MANNER OF
12 CARRYING OUT ROTH HSA DEPOSIT SYSTEM
13 (PATIENT-GRANT ELECTING STATE).—In mak-
14 ing the election under this subsection, a State
15 shall specify whether the State will carry out
16 subsection (b) or if such subsection shall be car-
17 ried out by means of the credit under section
18 36C of the Internal Revenue Code of 1986.

19 (4) ADDITIONAL AMOUNTS FOR POPULATION
20 HEALTH INITIATIVES FOR STATE ADMINISTERED
21 ROTH HSA DEPOSIT SYSTEM.—A patient-grant elect-
22 ing State (as defined in section 100(1)) is entitled
23 to receive additional funding under subsection (c) for
24 population health initiatives.

1 (b) DEPOSIT THROUGH PAYMENT INTO ROTH HSA
2 FOR DEPOSIT QUALIFYING RESIDENTS.—

3 (1) IN GENERAL.—The subsidies described in
4 subsection (a)(3) for an electing State shall be fur-
5 nished for each deposit qualifying resident through
6 the deposit of a contribution into a Roth HSA of the
7 individual in the amount determined under section
8 104. For purposes of the Internal Revenue Code of
9 1986, the amount of any contribution to a Roth
10 HSA made under this paragraph shall be included
11 in the gross income of the individual for whose ben-
12 efit the Roth HSA was established.

13 (2) DEPOSIT QUALIFYING RESIDENT DE-
14 FINED.—In this title, the term “deposit qualifying
15 resident” means, with respect to a State and a
16 month, an individual—

17 (A) who is a qualified resident (as defined
18 in section 100(14)) of the State as of the first
19 day of the month (or such other day in the
20 month as the Secretary may specify);

21 (B) with respect to whom a Roth HSA has
22 been established, which Roth HSA may have
23 been established by the State in carrying out
24 this section;

1 (C) who is enrolled in qualified health plan
 2 coverage (as defined in section 100(13)), which
 3 enrollment may have been effected by the State
 4 in carrying out this section; and

5 (D) who is not eligible for coverage under
 6 Medicare, is not enrolled for benefits under
 7 Medicaid or CHIP, and is not enrolled for bene-
 8 fits under chapter 55 of title 10, United States
 9 Code (relating to TRICARE), or title 39 of
 10 such Code (relating to veterans' benefits) or
 11 chapter 89 of title 5 of such Code (relating to
 12 the Federal Employees Health Benefits Pro-
 13 gram).

14 (3) PAYMENT ADMINISTRATION.—

15 (A) STATE.—In the case of an electing
 16 State that elects to carry out this subsection
 17 through the State, the Secretary shall provide
 18 for payment to the State in amounts and in a
 19 time and manner sufficient to permit the State
 20 to make timely monthly contributions to Roth
 21 HSAs under this subsection. The Secretary may
 22 provide for payment to the State using the pay-
 23 ment methodology described in subsection (d) of
 24 section 1903 of the Social Security Act for pay-
 25 ments under subsection (a) of such section (ap-

1 plied without regard to any State matching re-
 2 quirement) and may condition such payments
 3 upon the provision of such information as the
 4 Secretary may require to ensure the proper pay-
 5 ments under this subsection. As a condition of
 6 receiving payment under this section, a State
 7 shall submit such information, in such form,
 8 and manner, as the Secretary shall specify, in-
 9 cluding information necessary to make the com-
 10 putations of amounts under this section.

11 (B) FEDERAL.—In the case of a State
 12 electing to carry out this subsection other than
 13 through the State, subsidies described in sub-
 14 section (a)(3) shall be provided through a re-
 15 fundable tax credit under section 36C of the In-
 16 ternal Revenue Code of 1986.

17 (4) CONSTRUCTION.—Nothing in this sub-
 18 section shall be construed—

19 (A) to prevent an individual from affirma-
 20 tively electing not to have a Roth HSA estab-
 21 lished on the individual's behalf and not to be
 22 enrolled in health insurance coverage;

23 (B) subject to subparagraph (A), to pre-
 24 vent a State from establishing a Roth HSA for

each deposit qualifying resident who does not otherwise have a Roth HSA;

(C) subject to subparagraph (A), to prevent a State from establishing a mechanism whereby individuals who would be deposit qualifying residents but for paragraph (2)(C) are enrolled in health insurance coverage; and

(D) to prevent a State from changing its State Medicaid plan to eliminate coverage under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)), in order that individuals otherwise covered under such section may qualify for subsidies under this section.

(c) POPULATION HEALTH INITIATIVE FUNDING.—

(1) IN GENERAL.—In the case of an electing State for a year, the State is entitled to receive payment from the Secretary after the end of such year in an amount equal to 2 percent of the actual aggregate amount deposited under subsection (b) into Roth HSAs for residents of the State for the year.

(2) USE OF FUNDS.—Amounts paid to a State under paragraph (1) may only be used for population health initiatives (as defined by the Secretary).

1 (3) ENTITLEMENT.—Paragraph (1) constitutes
 2 budget authority in advance of appropriations Acts
 3 and represents the obligation of the Federal Govern-
 4 ment to provide for the payment to States of
 5 amounts provided under such paragraph.

6 (d) REQUIRING RULES FOR COMPUTING USUAL,
 7 CUSTOMARY, AND REASONABLE (UCR) PRICES.—As a
 8 condition for a State’s election of the alternative option
 9 under this section, the State must provide, through its de-
 10 partment of insurance or equivalent agency, for establish-
 11 ment of rules to carry out section 1867(j)(1)(A)(ii) of the
 12 Social Security Act, as added by section 121(a)(2).

13 **SEC. 104. COMPUTATION OF MONTHLY ROTH HSA DEPOSIT**
 14 **AMOUNT FOR DEPOSIT QUALIFYING RESI-**
 15 **DENTS.**

16 (a) COMPUTATION.—

17 (1) IN GENERAL.—The Secretary shall develop
 18 a standardized methodology to determine consistent
 19 with this section a monthly Roth HSA deposit
 20 amount for deposit qualifying residents in each State
 21 for months in each year. Subject to paragraphs (3)
 22 and (4), such amount shall be equal to $\frac{1}{12}$ of the
 23 average per capita annual amount computed under
 24 subsection (b) for the State for the year, as adjusted
 25 for the deposit qualifying resident involved—

1 (A) for age and geographic area under
 2 subsection (c); and

3 (B) for income under subsection (d).

4 (2) NO VARIATION BASED ON HOW DEPOSIT
 5 AMOUNT DISTRIBUTED.—Such amount shall be the
 6 same for a deposit qualifying individual without re-
 7 gard to whether the contribution to the individual’s
 8 Roth HSA is made by a State under this section or
 9 by the Federal Government through the operation of
 10 section 36C of the Internal Revenue Code of 1986.

11 (3) PATIENT-GRANT ELECTING STATE HAS
 12 FLEXIBILITY TO MAINTAIN LEVEL OF BENEFITS FOR
 13 CURRENT ACA BENEFICIARIES.—A patient-grant
 14 electing State may elect to increase the amount of
 15 the deposit for all deposit qualifying individuals
 16 under this section to the amounts that the Secretary
 17 estimates would have been paid with respect to such
 18 individuals under section 36B of the Internal Rev-
 19 enue Code of 1986 and section 1402 of PPACA if
 20 those sections had remained in effect in the State
 21 with respect to such individuals. Such election shall
 22 be made for a year and shall continue from year to
 23 year until the State elects to terminate such election.
 24 The Secretary shall, in conjunction with the Actu-
 25 ary, ensure such changes to the amount of deposit

1 for qualifying individuals shall remain budget neu-
 2 tral.

3 (4) SPECIAL RULE FOR PARTIAL DEPOSIT FOR
 4 LOW-INCOME INDIVIDUALS WITH EMPLOYER-SPON-
 5 SORED INSURANCE (ESI).—In the case of an indi-
 6 vidual who is covered under a group health plan and
 7 with respect to such coverage there is a contribution
 8 by an employer which is excluded from the individ-
 9 ual's gross income under the Internal Revenue Code
 10 of 1986, insofar as the individual is a deposit quali-
 11 fying resident, the amount of the deposit with re-
 12 spect to the individual shall be reduced, in a manner
 13 specified by the Secretary in consultation with the
 14 Secretary of the Treasury and taking into account
 15 the income of the individual's household, by an
 16 amount that is approximately equivalent to the esti-
 17 mated amount of the reduction in the amount of in-
 18 come tax resulting from such exclusion (and any re-
 19 duction in taxes imposed by chapter 21 or chapter
 20 2 of such Code by reason of any exclusion of such
 21 contributions from wages and self employment in-
 22 come).

23 (b) COMPUTATION OF UNADJUSTED AVERAGE PER
 24 CAPITA ANNUAL AMOUNT.—

1 (1) FOR STATES THAT CONTINUE PPACA MED-
 2 ICAID COVERAGE.—

3 (A) IN GENERAL.—In the case of a State
 4 that provides medical assistance under section
 5 1902(a)(10)(A)(i)(VIII) of the Social Security
 6 Act (42 U.S.C. 1396b(a)(10)(A)(i)(VIII)) dur-
 7 ing a year, subject to paragraphs (3) and (4),
 8 the Secretary shall compute an average per cap-
 9 ita annual amount for the State for the year
 10 equal to—

11 (i) the amount specified in subpara-
 12 graph (B), divided by

13 (ii) the average monthly number of
 14 deposit qualifying residents of the State in
 15 the year.

16 (B) AMOUNT BASED ON PPACA PROJECTED
 17 FEDERAL EXPENDITURES.—The amount speci-
 18 fied in this subparagraph for a State for a year
 19 is 95 percent of the Secretary’s estimate of the
 20 total payments that would have been made (as-
 21 suming the existence of a State established Ex-
 22 change in the State) under section 36B of the
 23 Internal Revenue Code of 1986 and under sec-
 24 tion 1402 of PPACA with respect to all quali-
 25 fied residents in the State in the year (or tax-

able year ending with such year, if applicable).

The Secretary shall, in conjunction with the Actuary, ensure such changes to the amount of deposit for qualifying individuals shall remain budget neutral.

(2) FOR STATES THAT DO NOT PROVIDE PPACA MEDICAID COVERAGE.—

(A) IN GENERAL.—In the case of a State not described in paragraph (1) for a year, subject to paragraphs (3) and (4), the Secretary shall compute an average per capita annual amount for the State for the year equal to—

(i) the amount specified in subparagraph (B) for the State and year, divided by

(ii) the average monthly number of deposit qualifying residents of the State in the year.

(B) AMOUNT BASED ON PPACA AND MEDICAID PROJECTED FEDERAL EXPENDITURES.—

The amount specified in this subparagraph for a State for a year is equal to the sum of—

(i) 95 percent of the Secretary's estimate of the total payments that would have been made (assuming the existence of

a State-established Exchange in the State) under section 36B of the Internal Revenue Code of 1986 and under section 1402 of PPACA with respect to all qualified residents in the year (or taxable year ending with such year, if applicable); and

(ii) the Secretary's estimate of the total payments that would have been made to the State under title XIX of the Social Security Act for individuals eligible to be covered under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act assuming the election of a State to provide Medicaid coverage under such section and assuming the applicable Federal medical assistance percentage were 95 percent with respect to such individuals.

(3) BUDGET NEUTRAL ADJUSTMENT IN PAYMENTS TO TAKE INTO ACCOUNT ELECTION OF HIGHER DEPOSITS TO MAINTAIN ACA SUBSIDY LEVELS.—
If a State makes the election described in subsection (a)(3) with respect to providing higher deposit amounts for certain individuals described in such subsection, then the Secretary shall adjust the aver-

1 age per capita annual amount under paragraph (1)
2 or (2), as applicable to the State, by—

3 (A) reducing the amount described in
4 paragraph (1)(B) (or, if applicable, paragraph
5 (2)(B)(i)) by an amount equal to 95 percent of
6 the aggregate increased deposit level attrib-
7 utable to subsection (a)(3); and

8 (B) not counting such an individual as a
9 qualifying resident for purposes of paragraph
10 (1)(A)(ii) (or, if applicable, paragraph
11 (2)(A)(ii)).

12 The Secretary shall, in conjunction with the Actu-
13 ary, ensure changes, as outlined in this subsection,
14 to the amount of deposit for qualifying individuals
15 shall remain budget neutral.

16 (4) ADJUSTMENT FOR COSTS OF PARTIAL DE-
17 POSITS FOR LOW-INCOME ESI INDIVIDUALS.—The
18 Secretary shall adjust the average per capita annual
19 amount under paragraph (1) or (2), as applicable to
20 the State, by—

21 (A) reducing the amount described in
22 paragraph (1)(B) (or, if applicable, paragraph
23 (2)(B)(i)) by an amount equal to 95 percent of
24 the amount of payments under this section that

1 are attributable to individuals described in sub-
 2 section (a)(4); and

3 (B) not counting any individual described
 4 in subsection (a)(4) as a qualifying resident for
 5 purposes of paragraph (1)(A)(ii) (or, if applica-
 6 ble, paragraph (2)(A)(ii)).

7 (c) ADJUSTMENT FOR AGE, GEOGRAPHIC AREA, AND
 8 INCOME DISTRIBUTION WITHIN STATE.—

9 (1) IN GENERAL.—The Secretary shall apply
 10 such adjustments to the per capita amount com-
 11 puted under subsection (b) as is designed to take
 12 into account, in a budget neutral manner and based
 13 on the costs estimated under paragraph (2), actu-
 14 arial differences in health care costs attributable to
 15 individuals in different age categories and different
 16 geographic locations of primary residences in the
 17 State and the reductions based on income under
 18 subsection (d). No such adjustment shall be made
 19 based on sex.

20 (2) DATA ON AVERAGE COSTS OF SERVICES.—
 21 Not later than December 15 before the beginning of
 22 each year, the Agency for Healthcare Research and
 23 Quality shall estimate the average cost of health
 24 care for such year for individuals under 65 years of
 25 age and may estimate how such average varies for

1 different populations of individuals under age 65.
 2 The adjustments under paragraph (1) for age cat-
 3 egories for a year shall be based on such estimates
 4 made. Not later than such date, the Secretary shall
 5 prescribe tables for purposes of making adjustments
 6 based on age under paragraph (1) based on such de-
 7 termination which shall apply for taxable years be-
 8 ginning in the succeeding calendar year.

9 (d) INCOME-RELATED PHASE-OUT.—

10 (1) IN GENERAL.—The per capita amount as
 11 computed under subsection (b) and adjusted and ap-
 12 plied to a deposit qualifying individual under sub-
 13 section (c) shall be multiplied by a phase-out per-
 14 centage equal to 100 percent reduced by 1 percent-
 15 age point for each \$1,000 (or fraction thereof) by
 16 which the taxpayer’s modified adjusted gross income
 17 for the taxable year exceeds \$90,000 (or, in the case
 18 of a joint return, \$150,000), multiplied, for a tax-
 19 able year ending in a year beginning after December
 20 31, 2015, by the cost-of-living adjustment for the
 21 year as described in section 1(f)(3) of the Internal
 22 Revenue Code of 1986, but substituting “2015” for
 23 “1992” in subparagraph (B) of such section.

24 (2) ZERO PER CAPITA AMOUNT FOR MARRIED
 25 FILING SEPARATELY.—The per capita amount under

1 this section shall be zero in the case of a married
2 couple filing separately.

3 **SEC. 105. STATE OPTIONS FOR IMPROVED ACCESS TO**
4 **HEALTH INSURANCE COVERAGE IN EACH**
5 **STATE.**

6 (a) STATE OPTIONS TO IMPROVE ACCESS.—

7 (1) IN GENERAL.—Each State may carry out
8 any of the functions described in this section in
9 order to improve the access of residents of the State
10 to health insurance coverage.

11 (2) REPURPOSING STATE EXCHANGES.—A
12 State may use or adapt an Exchange that the State
13 has established under title I of PPACA to carry out
14 any such function.

15 (3) REPURPOSING FEDERAL EXCHANGE.—The
16 Federal Government shall make available to States
17 current capabilities of the Federal Exchange, includ-
18 ing the Federal Data Services Hub and Agent
19 Broker Portal, to the extent requested by a State for
20 activities related to enrollment of citizens of the
21 State into health insurance coverage.

22 (b) TRANSPARENCY PORTAL.—Each State may es-
23 tablish and operate an open and transparent marketplace
24 mechanism whereby qualified residents of the State can
25 readily compare, through the use of the Internet, the bene-

1 fits and prices between different health insurance coverage
 2 options made available to them.

3 (c) ENROLLMENT, SUBJECT TO INDIVIDUAL OPT-
 4 OUT.—A State may provide for the enrollment of qualified
 5 residents of the State who are uninsured in default health
 6 insurance coverage offered under section 107(c) and es-
 7 tablishing a Roth HSA for such residents who do not have
 8 a Roth HSA unless the resident has affirmatively elected
 9 not to be so enrolled and not to have a Roth HSA, respec-
 10 tively. Any such enrollment under this paragraph shall be
 11 coordinated with the annual open enrollment periods pro-
 12 vided under section 107(b).

13 (d) RISK MITIGATION MECHANISMS AND REINSUR-
 14 ANCE AND RISK-CORRIDOR PROGRAMS.—

15 (1) IN GENERAL.—Notwithstanding any other
 16 provision of this title or section 223(c)(2) of the In-
 17 ternal Revenue Code of 1986, a State may estab-
 18 lish—

19 (A) mechanisms for risk mitigation or risk
 20 adjustment in order to limit volatility in the
 21 premiums based on health experience to class-
 22 average premiums; and

23 (B) a reinsurance and risk-corridor pro-
 24 gram that involves no Federal funds with re-

1 spect to coverage both in the individual market
2 and in the small group market.

3 (2) BASIS FOR RISK ADJUSTMENT.—Mecha-
4 nisms and programs under paragraph (1) may be
5 based on the health status score of each individual
6 enrolled in health insurance coverage in the indi-
7 vidual market and not solely based on the aggregate
8 risk of the risk pool with respect to each plan of
9 health insurance coverage.

10 (e) MODIFIED HEALTH STATUS INSURANCE MECHA-
11 NISM.—

12 (1) IN GENERAL.—A State may establish a
13 mechanism for providing modified health status in-
14 surance in the State to encourage health plans to
15 implement adequate benefit designs and services for
16 a chronically ill individual.

17 (2) REQUIREMENTS.—A mechanism under
18 paragraph (1) may implement the following require-
19 ments:

20 (A) During the first open enrollment pe-
21 riod after the date of enactment of this Act, an
22 individual health plan shall provide coverage for
23 health benefits as defined in the health plan for
24 a period of 12 months.

1 (B) If an individual enrolls in a new health
2 plan during the open enrollment period at the
3 end of the first 12 months of coverage under
4 subparagraph (A), the plan in which the indi-
5 vidual was enrolled prior to such period shall be
6 responsible for financing 75 percent of the
7 health benefits administered to the individual
8 under any other health plan in which the indi-
9 vidual enrolls for the initial 3-month period of
10 coverage under such other plan.

11 (C) During the 3-month period described
12 in subparagraph (B), the plan in which the in-
13 dividual was enrolled prior to such period shall
14 receive 75 percent of the premiums paid for the
15 individual's coverage under the other health
16 plan.

17 (D) During the third open enrollment pe-
18 riod after the date of enactment of this Act,
19 and during all subsequent open enrollment peri-
20 ods, a health plan that has enrollees terminate
21 their coverage in order to enroll in other health
22 plans shall be responsible for financing 75 per-
23 cent of the health benefits administered to such
24 enrollees under the other plans and shall receive
25 75 percent of the premiums paid for such en-

1 rollees' coverage under such other health plans
 2 for the first 3 months of coverage in the new
 3 plan year.

4 **SEC. 106. STATE FLEXIBILITY IN ENSURING ORDERLY**
 5 **HEALTH INSURANCE MARKET OUTSIDE OF**
 6 **AN EXCHANGE.**

7 (a) IN GENERAL.—With respect to health insurance
 8 coverage offered in a State, the State may, in consultation
 9 with the Secretary, take such steps, such as limiting the
 10 availability of general open enrollment periods, imposing
 11 delays in the effectiveness for coverage, permitting dif-
 12 ferentials in premiums based on age and other factors, as
 13 the State determines necessary in order to ensure an or-
 14 derly market for health insurance coverage in the State
 15 that is not offered through an Exchange. Such steps may
 16 include the establishment of an initial open enrollment pe-
 17 riod during which qualified residents may enroll in health
 18 insurance coverage without the imposition of any under-
 19 writing as the State determines to be appropriate in ensur-
 20 ing initial access to such coverage.

21 (b) FLEXIBILITY IN IMPOSING ADDITIONAL RE-
 22 QUIREMENTS.—Nothing in this section shall be construed
 23 as preventing a State from continuing to apply, to health
 24 insurance coverage issued in the State, requirements
 25 under the provisions of title XXVII of the Public Health

1 Service Act (as amended by subtitles A and C of title I
2 of PPACA), that are not continued under section 101(b).

3 (c) STATE FLEXIBILITY WITH RESPECT TO EX-
4 CHANGES.—A State may waive such provisions of part 2
5 of subtitle D of title I of PPACA, in relation to the estab-
6 lishment of an Exchange in such State, as the State deter-
7 mines appropriate in order for the State to implement and
8 administer a market-based system for the availability of
9 health insurance coverage throughout the State.

10 **SEC. 107. EXPANDED ACCESS AND PATIENT PROTECTIONS.**

11 (a) IN GENERAL.—As a condition for the election of
12 the alternative option under section 103 in a State, the
13 State must meet the requirements of this section.

14 (b) ANNUAL AND OTHER OPEN ENROLLMENT PERI-
15 ODS.—

16 (1) IN GENERAL.—The State shall require, in
17 connection with the offering of health insurance cov-
18 erage in the individual market in the State, that
19 there are uniform annual and other open enrollment
20 periods (such as those for changes in life events,
21 changes in State residency, and involuntary changes
22 in eligibility for coverage under a group health plan)
23 in order to permit qualified residents to enroll in
24 qualified health plan coverage in a manner that pro-
25 motes continuity of coverage. Such periods shall be

consistent with the open enrollment periods established under title I of PPACA, as in effect on the day before the date of the enactment of this Act.

(2) INITIAL OPEN ENROLLMENT PERIOD.—In addition, the State shall establish an initial open enrollment period during which qualified residents may enroll in qualified health plan coverage without the imposition of any underwriting described in subsection (d)(1)(B). Such period shall be a period of not less than 45 days and shall provide for enrollment to become effective on January 1 of the year specified by the State in which such State election first becomes effective.

(c) OFFERING OF DEFAULT HEALTH INSURANCE COVERAGE.—

(1) ENROLLMENT, SUBJECT TO INDIVIDUAL OPT-OUT.—Subject to paragraph (4), a State may elect to provide for the enrollment of residents of the State who are uninsured in default health insurance coverage (as defined in paragraph (2)) and establishing a Roth HSA for such residents who do not have a Roth HSA unless the resident has affirmatively elected not to be so enrolled and not to have such an account, respectively. If a State makes such

1 an election, the State shall permit eligible residents
 2 to enroll in such coverage on a continuous basis.

3 (2) DEFAULT HEALTH INSURANCE COVERAGE
 4 DEFINED.—In this subsection, the term “default
 5 health insurance coverage” means, with respect to a
 6 State, health insurance coverage that—

7 (A) is a high deductible health plan (within
 8 the meaning of section 223(c)(2) of the Internal
 9 Revenue Code of 1986) with prescription drug
 10 coverage limited to a Tier 1 formulary benefit
 11 (as commonly understood) for a limited number
 12 of chronic conditions (commonly referred to as
 13 tier I pharmacy benefit);

14 (B) meets such requirements as may apply
 15 to qualify for the payment of plan premiums
 16 from a health savings account under section
 17 223 of such Code (such as age-related pre-
 18 miums and limitation on imposition of pre-
 19 existing condition exclusions);

20 (C) has a provider network for covered
 21 benefits that is adequate (as determined con-
 22 sistent with the guidelines issued by the Sec-
 23 retary relating to provider access requirements
 24 for Medicare Advantage organizations under
 25 section 1852(d) of the Social Security Act (42

1 U.S.C. 1395w-22(d))) to ensure access to
 2 health benefits under such plan;

3 (D) provides for coverage of childhood im-
 4 munizations without cost sharing requirements
 5 to the extent such immunizations have in effect
 6 a recommendation from the Advisory Com-
 7 mittee on Immunization Practices of the Cen-
 8 ters for Disease Control and Prevention with
 9 respect to the individual involved; and

10 (E) meets such other requirements as the
 11 State may specify.

12 (3) ROTH HSA.—In this subsection, the term
 13 “Roth HSA” shall have the meaning given such
 14 term by section 530A(c) of the Internal Revenue
 15 Code of 1986.

16 (4) SIMPLE PROCESS FOR INDIVIDUALS TO OPT-
 17 OUT.—As a condition of a State providing for the
 18 enrollment function described in paragraph (1), the
 19 State shall establish an easy-to-use and transparent
 20 means by which individuals may elect not to be en-
 21 rolled in default health insurance coverage or to
 22 have a Roth HSA established on the individual’s be-
 23 half, or both.

24 (d) CONSEQUENCES RESPECTING CONTINUOUS COV-
 25 ERAGE.—

1 (1) CONSEQUENCES FOR NOT MAINTAINING
2 CONTINUOUS COVERAGE.—

3 (A) AVOIDANCE OF CONSEQUENCES BY
4 MAINTAINING CONTINUOUS COVERAGE.—

5 (i) IN GENERAL.—All qualified resi-
6 dents of a State are eligible during the ini-
7 tial open enrollment period provided under
8 subsection (b)(2) to enroll in qualified
9 health plan coverage and, thereafter, to
10 maintain continuous coverage in order to
11 avoid the adverse consequences described
12 in the succeeding provisions of this para-
13 graph.

14 (ii) SPECIAL ENROLLMENT PERI-
15 ODS.—The State may provide for special
16 enrollment periods based on birth, becom-
17 ing 26 years of age, and independence
18 from family coverage, during which certain
19 individuals will be eligible to enroll in
20 qualified health plan coverage for purposes
21 of this subsection.

22 (B) UNDERWRITING PERMITTED.—In the
23 case of a qualified resident of the State who
24 fails to maintain continuous creditable coverage

(not including any breaks in coverage of less than 63 days), the State shall—

(i) permit health insurance issuers for the period specified in subparagraph (C) to medically underwrite (through denial of health insurance coverage, application of preexisting condition limitations, differential premiums, or otherwise) the issuance of health insurance coverage, other than with respect to the issuance of default health insurance coverage under subsection (c); and

(ii) require health insurance issuers, during the subsequent 2-year period in the case of issuance of health insurance coverage other than such default health insurance coverage, to impose a monthly late enrollment penalty in the amount specified in subparagraph (D)(i) and to remit the amount of such penalty collected to the Federal Treasury in accordance with subparagraph (D)(ii).

(C) PERIOD FOR APPLICATION OF UNDERWRITING.—For purposes of subparagraph (B)(i), the period specified in this subparagraph

1 is, with respect to an uninsured individual as of
 2 a date, a period (not to exceed 18 months)
 3 equivalent to the number of months in the pre-
 4 vious 18-month period in which the individual
 5 did not have continuous creditable coverage de-
 6 scribed in subparagraph (B).

7 (D) MONTHLY LATE ENROLLMENT PEN-
 8 ALTY AMOUNT.—

9 (i) IN GENERAL.—The monthly late
 10 enrollment penalty amount specified in this
 11 clause for a month is equal to the lesser of
 12 10 percent or the product of—

13 (I) 1 percent of the monthly pre-
 14 mium amount for default health in-
 15 surance coverage with respect to the
 16 individual and month; and

17 (II) the number of months dur-
 18 ing the 2-year period (preceding the
 19 18-month period described in subpara-
 20 graph (B)(i)) in which the resident
 21 failed to maintain the continuous cov-
 22 erage described in paragraph (1)(D).

23 (ii) PAYMENT OF PENALTY AMOUNT
 24 TO FEDERAL TREASURY.—The amount of
 25 the monthly late enrollment penalty col-

lected under this subparagraph shall be paid to the Treasury of the United States in a form and manner specified by the Secretary of the Treasury.

(2) CHANGES IN ENROLLMENT PERMITTED WITHOUT MEDICAL UNDERWRITING DURING ANNUAL OPEN ENROLLMENT PERIODS FOR THOSE MAINTAINING CONTINUOUS COVERAGE.—

(A) DURING SECOND OPEN ENROLLMENT PERIOD.—In the case of a qualified resident who maintains continuous coverage (not including any breaks in coverage of less than 63 days) during the period after the initial open enrollment period under subsection (b)(2) and through the second annual open enrollment period established by the State consistent with subsection (b)(1), the State shall require health insurance issuers to permit such residents during such second annual open enrollment period to change the qualified health plan coverage in which the individual is enrolled without medical underwriting.

(B) DURING THIRD AND SUBSEQUENT OPEN ENROLLMENT PERIODS.—In the case of a qualified resident who maintains continuous

1 coverage for a period of 18 months or longer
 2 (not including any breaks in coverage of less
 3 than 63 days) as of the initial date of a third
 4 or subsequent annual open enrollment period
 5 established by the State under subsection
 6 (b)(1), the State shall require health insurance
 7 issuers to permit such residents during such an
 8 open enrollment period to change the qualified
 9 health plan coverage in which the individual is
 10 enrolled without medical underwriting.

11 **SEC. 108. APPLICATION OF HEALTH SAVINGS ACCOUNTS IN**
 12 **RELATION TO MEDICAID.**

13 (a) IN GENERAL.—Title XIX of the Social Security
 14 Act (42 U.S.C. 1396 et seq.) is amended by adding at
 15 the end the following new section:

16 **“SEC. 1947. PROVISIONS RELATING TO HEALTH SAVINGS**
 17 **ACCOUNTS.**

18 “(a) DISREGARDING ROTH HSA IN DETERMINING
 19 ASSETS AND INCOME FOR MEDICAID ELIGIBILITY DE-
 20 TERMINATIONS OTHER THAN FOR LONG-TERM CARE
 21 SERVICES.—The assets in a health savings account under
 22 section 223 of the Internal Revenue Code of 1986, and
 23 any income from such assets in such account, shall be dis-
 24 regarded for purposes of determining eligibility for and
 25 amount of medical assistance under this title, other than

1 for purposes of determining eligibility for and the amount
 2 of medical assistance for long-term care services (de-
 3 scribed in section 1917(c)(1)(C)(i)).

4 “(b) NOTIFICATIONS OF TREASURY OF MEDICAID
 5 ELIGIBILITY.—In order to meet the requirements of this
 6 subsection (for purposes of section 1902(a)(78)), a State
 7 shall provide such notice to the Secretary of the Treasury,
 8 in such form and manner as the Secretary shall specify,
 9 as may be necessary to identify individuals who are eligible
 10 for, and receiving, medical assistance under this title in
 11 a month in order to carry out section 223 of the Internal
 12 Revenue Code of 1986.”.

13 (b) IMPLEMENTATION OF NOTIFICATION REQUIRE-
 14 MENT THROUGH STATE PLAN.—Section 1902(a) of the
 15 Social Security Act (42 U.S.C. 1396a(a)) is amended by
 16 inserting after paragraph (77) the following new para-
 17 graph:

18 “(78) provide for notice in accordance with sec-
 19 tion 1947(b) to the Secretary of the Treasury of the
 20 identity of individuals who are eligible for and re-
 21 ceiving medical assistance under this title;”.

22 (c) EFFECTIVE DATE.—The amendments made by
 23 this section shall apply to eligibility determinations with
 24 respect to medical assistance for periods beginning on or
 25 after January 1, 2018.

1 **Subtitle B—Provider Price** 2 **Transparency**

3 **SEC. 121. ENSURING ACCESS TO EMERGENCY SERVICES** 4 **WITHOUT EXCESSIVE CHARGES FOR OUT-OF-** 5 **NETWORK SERVICES.**

6 (a) IN GENERAL.—Section 1867 of the Social Secu-
7 rity Act (42 U.S.C. 1395dd) is amended—

8 (1) in subsection (d), by adding at the end the
9 following new paragraph:

10 “(5) ENFORCEMENT WITH RESPECT TO EXCES-
11 SIVE CHARGES.—A hospital, physician, or other enti-
12 ty that violates the requirements of subsection (j)(1)
13 with respect to the furnishing of items and services
14 is subject to a civil money penalty of not more than
15 \$25,000 for each such violation. The provisions of
16 section 1128A (other than subsections (a) and (b))
17 shall apply to a civil money penalty under this para-
18 graph in the same manner as such provisions apply
19 with respect to a penalty or proceeding under section
20 1128A(a).”; and

21 (2) by adding at the end the following new sub-
22 section:

23 “(j) PROTECTIONS AGAINST EXCESSIVE OUT-OF-
24 NETWORK CHARGES FOR EMERGENCY SERVICES.—

1 “(1) IN GENERAL.—In the absence of State
 2 regulations, if items or services to screen or treat an
 3 emergency medical condition are furnished under
 4 this section in a participating hospital with respect
 5 to an individual and the individual has not, directly
 6 or through a health insurance issuer, group health
 7 plan, or other third party, negotiated a payment rate
 8 for such items and services, subject to paragraph
 9 (2), the charges imposed for such items and services
 10 may not be in excess of the following:

11 “(A) PHYSICIANS’ AND OTHER PROFES-
 12 SIONAL SERVICES.—For physicians’ services or
 13 services of a health care provider which con-
 14 stitute medical care (as defined under section
 15 213(d) of the Internal Revenue Code of 1986,
 16 as in effect before the date of the enactment of
 17 this subsection) (and including drugs and
 18 biologicals furnished in conjunction with and
 19 billed as part of such services), the lesser of—

20 “(i) the cash price for such services
 21 posted pursuant to section 121(b) of the
 22 Patient Freedom Act of 2017; or

23 “(ii) 85 percent of the usual, cus-
 24 tomary, and reasonable (UCR) charge for
 25 such services, as determined under rules

1 established by the department of insurance
2 for the State in which the services are fur-
3 nished.

4 “(B) HOSPITAL SERVICES.—For inpatient
5 and outpatient hospital services for which pay-
6 ment rates are established under this title (and
7 including drugs and biologicals furnished in
8 conjunction with and billed as part of such
9 services), the lesser of—

10 “(i) the cash price for such services
11 posted pursuant to section 121(b) of the
12 Patient Freedom Act of 2017; or

13 “(ii) 110 percent of the payment rate
14 applicable to such services in the case of
15 an individual entitled to benefits under
16 part A and enrolled under part B.

17 “(C) DRUGS AND BIOLOGICALS.—For
18 drugs and other pharmaceuticals furnished to
19 which a previous subparagraph does not apply,
20 the lesser of—

21 “(i) twice the acquisition cost to the
22 hospital or other provider for the dose in-
23 volved; or

24 “(ii) the acquisition cost to the hos-
25 pital or other provider plus \$250.

1 The dollar amount in clause (ii) shall be in-
 2 creased from year to year (beginning with the
 3 year after the first year in which this subsection
 4 applies) by the same percentage as the percent-
 5 age increase in the consumer price index for all
 6 urban consumers (all items; U.S. city average)
 7 for the year involved (as determined by the Sec-
 8 retary). Any such dollar amount as so increased
 9 that is not a multiple of \$5 shall be rounded to
 10 the nearest multiple of \$5 (or, if a multiple of
 11 \$2.50, to the next highest multiple of \$5).

12 “(D) OTHER ITEMS AND SERVICES.—For
 13 any other items or services, the lesser of—

14 “(i) the cash price for such items and
 15 services posted pursuant to section 121(b)
 16 of the Patient Freedom Act of 2017; or

17 “(ii) 110 percent of the payment basis
 18 that would be applicable to payment for
 19 such items and services under this title in
 20 the case of an individual entitled to bene-
 21 fits under part A and enrolled under part
 22 B.

23 “(2) SPECIAL RULE FOR ITEMS AND SERVICES
 24 FURNISHED AS A BUNDLE.—In the case of items
 25 and services for which there is a single price for a

group or bundle of such items and services, the maximum charge permitted under paragraph (1) may not exceed the lesser of—

“(A) the price charged for such bundled services; or

“(B) the aggregate of the maximum charges permitted under paragraph (1) with respect to items and services included in such bundle.”.

(b) REFERENCE TO PRICE DISCLOSURE PROVISION.—

(1) IN GENERAL.—Persons providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986, as in effect before the date of the enactment of this Act) are required to post prices under this subsection.

(2) FORM OF DISCLOSURE.—The disclosure of prices under this subsection shall be in a form and manner specified by the Secretary, in consultation with the Secretary of the Treasury, and shall be designed—

(A) to establish a single price for related items and services in a manner similar to the manner in which pricing and payment for such items and services is provided under the Medi-

1 care program under title XVIII of the Social
 2 Security Act (42 U.S.C. 1395 et seq.); and

3 (B) to make it easy for consumers to com-
 4 pare the prices for similar items and services
 5 furnished by different providers.

6 (c) EFFECTIVE DATE.—The amendments made by
 7 this section shall apply to charges imposed for items and
 8 services furnished on or after January 1, 2018.

9 **TITLE II—REFORM OF TAX PRO-**
 10 **VISIONS RELATING TO**
 11 **HEALTH CARE**

12 **Subtitle A—Health Savings**
 13 **Accounts**

14 **SEC. 201. TRANSITION TO NON-DEDUCTIBLE HSAS.**

15 (a) NON-DEDUCTIBLE HSAS.—Subchapter F of
 16 chapter 1 of the Internal Revenue Code of 1986 is amend-
 17 ed by adding at the end the following new part:

18 **“PART IX—HEALTH SAVINGS ACCOUNTS**

“Sec. 530A. Roth HSAs.

19 **“SEC. 530A. ROTH HSAS.**

20 “(a) IN GENERAL.—With the exception of the taxes
 21 imposed by section 511 (relating to imposition of tax on
 22 unrelated business income of charitable organizations), a
 23 Roth HSA shall be exempt from taxation under this sub-

1 title. No deduction shall be allowed for any contribution
 2 to a Roth HSA.

3 “(b) DOLLAR LIMITATION.—

4 “(1) IN GENERAL.—The aggregate amount of
 5 contributions for any taxable year to all Roth HSAs
 6 maintained for the benefit of an individual shall not
 7 exceed the sum of the monthly limitations for any
 8 month during such taxable year that the individual
 9 is an eligible individual.

10 “(2) MONTHLY LIMITATION.—The monthly lim-
 11 itation for any month is $\frac{1}{12}$ of—

12 “(A) in the case of an eligible individual
 13 who has self-only creditable coverage as of the
 14 first day of such month, \$5,000, and

15 “(B) in the case of an eligible individual
 16 who has family creditable coverage as of the
 17 first day of such month, the amount in effect
 18 under subparagraph (A) for the taxable year
 19 multiplied by the number of individuals (includ-
 20 ing the eligible individual) covered under such
 21 family creditable coverage as of such day.

22 “(3) ADDITIONAL CONTRIBUTIONS FOR INDIVIDUALS 55 OR OLDER.—In the case of an individual
 23 who has attained age 55 before the close of the tax-
 24 able year, the applicable limitation under subpara-
 25

graphs (A) and (B) of paragraph (2) shall be increased by \$1,000.

“(4) COORDINATION WITH OTHER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to an individual for any taxable year shall be reduced (but not below zero) by the sum of—

“(A) the aggregate amount paid for such taxable year to Archer MSAs of such individual, and

“(B) the aggregate amount contributed to Roth HSAs of such individual for such taxable year under section 408(d)(9).

Subparagraph (A) shall not apply with respect to any individual to whom paragraph (5) applies.

“(5) SPECIAL RULE FOR MARRIED INDIVIDUALS.—In the case of individuals who are married to each other, if either spouse has family coverage—

“(A) both spouses shall be treated as having only such family coverage (and if such spouses each have family coverage under different plans, as having the family coverage with the lowest annual deductible), and

“(B) the limitation under paragraph (1) (after the application of subparagraph (A) and

1 without regard to any additional contribution
 2 amount under paragraph (3))—

3 “(i) shall be reduced by the aggregate
 4 amount paid to Archer MSAs of such
 5 spouses for the taxable year, and

6 “(ii) after such reduction, shall be di-
 7 vided equally between them unless they
 8 agree on a different division.

9 “(6) DENIAL OF DEDUCTION TO DEPEND-
 10 ENTS.—No contribution may be made to a Roth
 11 HSA under this section by any individual with re-
 12 spect to whom a deduction under section 151 is al-
 13 lowable to another taxpayer for a taxable year begin-
 14 ning in the calendar year in which such individual’s
 15 taxable year begins.

16 “(7) MEDICARE ELIGIBLE INDIVIDUALS.—The
 17 limitation under this subsection for any month with
 18 respect to an individual shall be zero for the first
 19 month such individual is entitled to benefits under
 20 title XVIII of the Social Security Act and for each
 21 month thereafter.

22 “(8) INCREASE IN LIMIT FOR INDIVIDUALS BE-
 23 COMING ELIGIBLE INDIVIDUALS AFTER THE BEGIN-
 24 NING OF THE YEAR.—

1 “(A) IN GENERAL.—For purposes of com-
 2 puting the limitation under paragraph (1) for
 3 any taxable year, an individual who is an eligi-
 4 ble individual during the last month of such
 5 taxable year shall be treated—

6 “(i) as having been an eligible indi-
 7 vidual during each of the months in such
 8 taxable year, and

9 “(ii) as having been enrolled, during
 10 each of the months such individual is
 11 treated as an eligible individual solely by
 12 reason of clause (i), in the same health
 13 plan in which the individual was enrolled
 14 for the last month of such taxable year.

15 “(B) FAILURE TO MAINTAIN CREDITABLE
 16 COVERAGE.—

17 “(i) IN GENERAL.—If, at any time
 18 during the testing period, the individual is
 19 not an eligible individual, then—

20 “(I) the gross income of the indi-
 21 vidual for the taxable year in which
 22 occurs the first month in the testing
 23 period for which such individual is not
 24 an eligible individual shall be in-
 25 creased by the aggregate amount of

1 all contributions to the Roth HSA of
 2 the individual which could not have
 3 been made but for subparagraph (A),
 4 and

5 “(II) the tax imposed by this
 6 chapter for any taxable year on the
 7 individual shall be increased by 10
 8 percent of the amount of such in-
 9 crease.

10 “(ii) EXCEPTION FOR DISABILITY OR
 11 DEATH.—Clause (i) shall not apply if the
 12 individual ceased to be an eligible indi-
 13 vidual by reason of the death of the indi-
 14 vidual or the individual becoming disabled
 15 (within the meaning of section 72(m)(7)).

16 “(iii) TESTING PERIOD.—The term
 17 ‘testing period’ means the period beginning
 18 with the last month of the taxable year re-
 19 ferred to in subparagraph (A) and ending
 20 on the last day of the 12th month fol-
 21 lowing such month.

22 “(9) LIMITATION NOT TO APPLY TO CERTAIN
 23 CONTRIBUTIONS MADE UNDER PATIENT FREEDOM
 24 ACT.—Any contributions made under 103(b) of the
 25 Patient Freedom Act of 2017 or as provided in sec-

tion 36C shall not be taken into account for purposes of determining whether the limitation under paragraph (1) has been met.

“(c) ROTH HSA.—For purposes of this title—

“(1) IN GENERAL.—The term ‘Roth HSA’ or ‘Roth health savings account’ means a trust created or organized in the United States as a Roth HSA exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the following requirements:

“(A) Except in the case of a rollover contribution described in subsection (e)(5) or section 220(f)(5) or 223(f)(5), no contribution will be accepted—

“(i) unless it is in cash, or

“(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds the sum of—

“(I) the dollar amount in effect under subsection (b)(2)(B), and

“(II) the dollar amount in effect under subsection (b)(3).

“(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

“(C) No part of the trust assets will be invested in life insurance contracts.

“(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

“(E) The interest of an individual in the balance in his account is nonforfeitable.

“(2) QUALIFIED MEDICAL EXPENSES.—For purposes of this section—

“(A) IN GENERAL.—The term ‘qualified medical expenses’ means, with respect to an account beneficiary, amounts paid by such beneficiary for medical care (as defined in section 213(d) as in effect on the day before the date of the enactment of the Patient Freedom Act of 2017) for such individual, the spouse of such individual, and any dependent (as defined in

1 section 152, determined without regard to sub-
 2 sections (b)(1), (b)(2), and (d)(1)(B) thereof
 3 of such individual, but only to the extent such
 4 amounts are not compensated for by insurance
 5 or otherwise.

6 “(B) LIMITATION ON HEALTH INSURANCE
 7 PURCHASED FROM ACCOUNT.—Such term shall
 8 not include any payment for health benefits cov-
 9 erage that is not creditable coverage (within the
 10 meaning of title XXVII of the Public Health
 11 Service Act).

12 “(C) EXCEPTIONS.—Subparagraph (B)
 13 shall not apply to any expense for coverage
 14 under—

15 “(i) a health plan during any period
 16 of continuation coverage required under
 17 any Federal law,

18 “(ii) a qualified long-term care insur-
 19 ance contract (as defined in section
 20 7702B(b)),

21 “(iii) a health plan during a period in
 22 which the individual is receiving unemploy-
 23 ment compensation under any Federal or
 24 State law, or

1 “(iv) in the case of an account bene-
 2 ficiary who has attained the age specified
 3 in section 1811 of the Social Security Act,
 4 any health insurance other than a medi-
 5 care supplemental policy (as defined in sec-
 6 tion 1882 of the Social Security Act).

7 “(3) ACCOUNT BENEFICIARY.—The term ‘ac-
 8 count beneficiary’ means the individual on whose be-
 9 half the Roth HSA was established.

10 “(4) CERTAIN RULES TO APPLY.—Rules similar
 11 to the following rules shall apply for purposes of this
 12 section:

13 “(A) Section 219(f)(3) (relating to time
 14 when contributions deemed made).

15 “(B) Section 219(f)(5) (relating to em-
 16 ployer payments).

17 “(C) Section 408(g) (relating to commu-
 18 nity property laws).

19 “(D) Section 408(h) (relating to custodial
 20 accounts).

21 “(5) ACCOUNT TERMINATIONS.—Rules similar
 22 to the rules of paragraphs (2) and (4) of section
 23 408(e) shall apply to Roth HSAs, and any amount
 24 treated as distributed under such rules shall be

1 treated as not used to pay qualified medical ex-
2 penses.

3 “(d) ELIGIBLE INDIVIDUAL.—For purposes of this
4 section, the term ‘eligible individual’ means, with respect
5 to any month, any individual who is covered under cred-
6 itable coverage (within the meaning of title XXVII of the
7 Public Health Service Act) as of the 1st day of such
8 month.

9 “(e) TAX TREATMENT OF DISTRIBUTIONS.—

10 “(1) AMOUNTS USED FOR QUALIFIED MEDICAL
11 EXPENSES.—Any amount paid or distributed out of
12 a Roth HSA which is used exclusively to pay quali-
13 fied medical expenses of any account beneficiary
14 shall not be includible in gross income in the manner
15 provided in section 72.

16 “(2) INCLUSION OF AMOUNTS NOT USED FOR
17 QUALIFIED MEDICAL EXPENSES.—Any amount paid
18 or distributed out of a Roth HSA which is not used
19 exclusively to pay the qualified medical expenses of
20 the account beneficiary shall be included in the gross
21 income of such beneficiary.

22 “(3) EXCESS CONTRIBUTIONS RETURNED BE-
23 FORE DUE DATE OF RETURN.—

24 “(A) IN GENERAL.—If any excess con-
25 tribution is contributed for a taxable year to

any Roth HSA of an individual, paragraph (2) shall not apply to distributions from the Roth HSAs of such individual (to the extent such distributions do not exceed the aggregate excess contributions to all such accounts of such individual for such year) if—

“(i) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual’s return for such taxable year, and

“(ii) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in clause (ii) shall be included in the gross income of the individual for the taxable year in which it is received.

“(B) EXCESS CONTRIBUTION.—For purposes of subparagraph (A), the term ‘excess contribution’ means any contribution (other than a rollover contribution described in paragraph (5) or section 220(f)(5) or 223(f)(5)) which exceeds the contribution limitation with respect to the individual for the taxable year.

1 “(4) ADDITIONAL TAX ON DISTRIBUTIONS NOT
2 USED FOR QUALIFIED MEDICAL EXPENSES.—

3 “(A) IN GENERAL.—The tax imposed by
4 this chapter on the account beneficiary for any
5 taxable year in which there is a payment or dis-
6 tribution from a Roth HSA of such beneficiary
7 which is includible in gross income under para-
8 graph (2) shall be increased by 10 percent of
9 the amount which is so includible.

10 “(B) EXCEPTION FOR DISABILITY OR
11 DEATH.—Subparagraph (A) shall not apply if
12 the payment or distribution is made after the
13 account beneficiary becomes disabled within the
14 meaning of section 72(m)(7) or dies.

15 “(C) EXCEPTION FOR DISTRIBUTIONS
16 AFTER MEDICARE ELIGIBILITY.—Subparagraph
17 (A) shall not apply to any payment or distribu-
18 tion after the date on which the account bene-
19 ficiary attains the age specified in section 1811
20 of the Social Security Act.

21 “(5) ROLLOVER CONTRIBUTION.—An amount is
22 described in this paragraph as a rollover contribu-
23 tion if it meets the requirements of subparagraphs
24 (A) and (B).

1 “(A) IN GENERAL.—Paragraph (2) shall
2 not apply to any amount paid or distributed
3 from a health savings account (as defined in
4 section 223) or a Roth HSA to the account
5 beneficiary to the extent the amount received is
6 paid into a Roth HSA for the benefit of such
7 beneficiary not later than the 60th day after
8 the day on which the beneficiary receives the
9 payment or distribution.

10 “(B) LIMITATION.—This paragraph shall
11 not apply to any amount described in subpara-
12 graph (A) received by an individual from a
13 health savings account or a Roth HSA if, at
14 any time during the 1-year period ending on the
15 day of such receipt, such individual received any
16 other amount described in subparagraph (A)
17 from a health savings account or Roth HSA
18 which was not includible in the individual’s
19 gross income because of the application of this
20 paragraph.

21 “(6) TRANSFER OF ACCOUNT INCIDENT TO DI-
22 VORCE.—The transfer of an individual’s interest in
23 a Roth HSA to an individual’s spouse or former
24 spouse under a divorce or separation instrument de-
25 scribed in subparagraph (A) of section 71(b)(2) shall

not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a Roth HSA with respect to which such spouse is the account beneficiary.

“(7) TREATMENT AFTER DEATH OF ACCOUNT BENEFICIARY.—If an individual acquires an account beneficiary’s interest in a health savings account by reason of the death of the account beneficiary, such health savings account shall be treated as if the individual were the account beneficiary.

“(f) COST-OF-LIVING ADJUSTMENT.—

“(1) IN GENERAL.—In the case of any calendar year beginning after 2017, the \$5,000 dollar amount in subsection (b)(2) shall be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined—

“(i) by substituting ‘calendar year 2016’ for ‘calendar year 1992’ in subparagraph (B) thereof, and

“(ii) by substituting ‘CPI medical care component’ for ‘CPI’.

1 “(2) CPI MEDICAL CARE COMPONENT.—For
2 purposes of this paragraph, the term ‘CPI medical
3 care component’ means the medical care component
4 for the Consumer Price Index for All Urban Con-
5 sumers published by the Department of Labor.

6 “(3) ROUNDING.—If the amount of any in-
7 crease under the preceding sentence is not a mul-
8 tiple of \$50, such increase shall be rounded to the
9 next lowest multiple of \$50.

10 “(g) REPORTS.—The Secretary may require—

11 “(1) the trustee of a Roth HSA to make such
12 reports regarding such account to the Secretary and
13 to the account beneficiary with respect to contribu-
14 tions, distributions, the return of excess contribu-
15 tions, and such other matters as the Secretary deter-
16 mines appropriate, and

17 “(2) any person who provides an individual with
18 creditable coverage to make such reports to the Sec-
19 retary and to the account beneficiary with respect to
20 such plan as the Secretary determines appropriate.

21 The reports required by this subsection shall be filed at
22 such time and in such manner and furnished to such indi-
23 viduals at such time and in such manner as may be re-
24 quired by the Secretary.”.

1 (b) LIMIT ON CONTRIBUTIONS TO DEDUCTIBLE
 2 HEALTH SAVINGS ACCOUNTS.—Section 223 of such Code
 3 is amended by adding at the end the following new sub-
 4 section:

5 “(i) LIMITED CONTRIBUTIONS AFTER 2016.—

6 “(1) IN GENERAL.—No contribution may be ac-
 7 cepted by a health savings account after the date of
 8 the enactment of this subsection.

9 “(2) EXCEPTIONS.—Paragraph (1) shall not
 10 apply to a rollover contribution described in sub-
 11 section (f)(5).”.

12 (c) CONFORMING AMENDMENTS.—

13 (1) Section 26(b)(2) of the Internal Revenue
 14 Code of 1986 is amended—

15 (A) in subparagraph (S), by striking “and
 16 408(d)(9)(D)(i)(II)” and inserting
 17 “408(d)(9)(D)(i)(II), and
 18 530A(b)(8)(B)(i)(II)”, and

19 (B) in subparagraph (U), by inserting
 20 “and section 530A(e)(4)” before the comma at
 21 the end.

22 (2) Section 35(g)(3) of such Code is amended—

23 (A) by striking “or from” and inserting “,
 24 from”, and

1 (B) by inserting “or from a Roth HSA (as
2 defined in section 530A(c))” after “223(d))”.

3 (3) Section 220(f)(5)(A) of such Code is
4 amended by inserting “or a Roth HSA (as defined
5 in section 530A(c))” after “223(d))”.

6 (4) Section 223(f)(5)(A) of such Code is
7 amended by inserting “or a Roth HSA (as defined
8 in section 530A(c))” after “paid into a health sav-
9 ings account”.

10 (5) Section 408(d)(9) of such Code is amended
11 by adding at the end the following new subpara-
12 graph:

13 “(F) APPLICATION TO ROTH HSAS.—Rules
14 similar to the rules of the preceding subpara-
15 graphs of this paragraph shall apply with re-
16 spect to eligible individuals (as defined in sec-
17 tion 530A(d)) making contributions to Roth
18 HSAs, except that subparagraph (C) shall be
19 applied by substituting ‘section 530A(b)’ for
20 ‘section 223(b)’.”.

21 (6) Section 848(e)(1)(B)(v) of such Code is
22 amended by inserting “or a Roth HSA (as defined
23 in section 530A(c))” after “223(d))”.

1 (7) Section 877A(e)(2) of such Code is amend-
 2 ed by inserting “a Roth HSA (as defined in section
 3 530A(c),” after “223),”.

4 (8) Section 4973 of such Code is amended—

5 (A) in subsection (a), by striking “or” at
 6 the end of paragraph (5), by inserting “or” at
 7 the end of paragraph (6), and by inserting after
 8 paragraph (6) the following new paragraph:

9 “(7) a Roth HSA (within the meaning of sec-
 10 tion 530A),”, and

11 (B) by adding at the end the following new
 12 subsection:

13 “(j) EXCESS CONTRIBUTION TO ROTH HSAs.—For
 14 purposes of this section, in the case of Roth HSA (within
 15 the meaning of section 530A(c)), the term ‘excess con-
 16 tributions’ means the sum of—

17 “(1) the aggregate amount contributed for the
 18 taxable year to the accounts (other than a rollover
 19 contribution described in section 220(f)(5),
 20 223(f)(5), or 530A(e)(5)), and

21 “(2) the amount determined under this sub-
 22 section for the preceding taxable year, reduced by
 23 the sum of—

1 “(A) the distributions out of the accounts
 2 which were included in gross income under sec-
 3 tion 530A(e)(2), and

4 “(B) the excess (if any) of—

5 “(i) the maximum amount allowable
 6 as a contribution under section 530A(b)
 7 for the taxable year, over

8 “(ii) the amount contributed to the
 9 accounts for the taxable year.

10 For purposes of this subsection, any contribution which
 11 is distributed out of the Roth HSA in a distribution to
 12 which section 530A(e)(3) applies shall be treated as an
 13 amount not contributed.”.

14 (9) Section 4975(c) of such Code is amended by
 15 adding at the end the following new paragraph:

16 “(7) SPECIAL RULE FOR ROTH HSAS.—An indi-
 17 vidual for whose benefit a Roth HSA (within the
 18 meaning of section 530A(c)) is established shall be
 19 exempt from the tax imposed by this section with re-
 20 spect to any transaction concerning such account
 21 (which would otherwise be taxable under this sec-
 22 tion) if, with respect to such transaction, the ac-
 23 count ceases to be a Roth HSA by reason of the ap-
 24 plication of section 530A(c)(5) to such account.”.

1 (10) Section 6051(a)(12) of such Code is
2 amended by inserting “and to any Roth HSA (as de-
3 fined in section 530A(c))” after “223(d))”.

4 (11) Section 6693(a)(2) of such Code is amend-
5 ed by striking “and” at the end of subparagraph
6 (E), by striking the period at the end of subpara-
7 graph (F) and inserting “, and”, and by adding at
8 the end the following new subparagraph:

9 “(G) section 530A(g) (relating to Roth
10 HSAs).”.

11 (d) CLERICAL AMENDMENT.—The table of parts for
12 subchapter F of chapter 1 of such Code is amended by
13 adding at the end the following new item:

 “PART IX. ROTH HEALTH SAVINGS ACCOUNTS”.

14 (e) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to taxable years beginning after
16 December 31, 2016.

17 **SEC. 202. TREATMENT OF DIRECT PRIMARY CARE.**

18 (a) HSAs.—

19 (1) ROTH HSA.—Section 530A(c)(2)(A) of the
20 Internal Revenue Code of 1986, as added by this
21 Act, is amended by adding at the end the following:

22 “Such term shall include the payment of a monthly
23 or other prepaid amount for the furnishing (or ac-
24 cess to the furnishing) by a physician or group of

1 physicians of physician professional services (and an-
 2 cillary services).”.

3 (2) HSA.—Section 223(d)(2)(A) of such Code
 4 is amended by adding at the end the following:
 5 “Such term shall include the payment of a monthly
 6 or other prepaid amount for the furnishing (or ac-
 7 cess to the furnishing) by a physician or group of
 8 physicians of physician professional services (and an-
 9 cillary services).”.

10 (b) NOT TREATED AS HEALTH INSURANCE COV-
 11 ERAGE.—

12 (1) IN GENERAL.—For purposes of title XXVII
 13 of the Public Health Service Act, subtitle B of title
 14 I of the Employee Retirement Income Security Act
 15 of 1974, PPACA, and this Act, the offering of direct
 16 primary care shall not be treated as the offering of
 17 health insurance coverage and shall not be subject to
 18 regulations as such coverage under such Acts.

19 (2) DIRECT PRIMARY CARE DEFINED.—In this
 20 subsection, the term “direct primary care” means
 21 the furnishing (or access to the furnishing) by a
 22 physician or group of physicians of physician profes-
 23 sional services (and ancillary services) in return for
 24 payment of a monthly or other prepaid amount.

1 **SEC. 203. TREATMENT OF HSA AFTER DEATH OF ACCOUNT**
 2 **BENEFICIARY.**

3 (a) IN GENERAL.—Section 223(e)(8) of the Internal
 4 Revenue Code of 1986, as redesignated by section
 5 201(c)(3) of this Act, is amended to read as follows:

6 “(8) TREATMENT AFTER DEATH OF ACCOUNT
 7 BENEFICIARY.—If an individual acquires an account
 8 beneficiary’s interest in a health savings account by
 9 reason of the death of the account beneficiary, such
 10 health savings account shall be treated as if the indi-
 11 vidual were the account beneficiary.”.

12 (b) EFFECTIVE DATE.—The amendment made by
 13 this section shall apply with respect to interests acquired
 14 after the date of the enactment of this Act.

15 **Subtitle B—Health Care Tax**
 16 **Credits**

17 **SEC. 211. LIMITED APPLICATION OF PPACA HEALTH PRE-**
 18 **MIUM CREDIT.**

19 (a) IN GENERAL.—Section 36B(e)(1) of the Internal
 20 Revenue Code of 1986 is amended by adding at the end
 21 the following:

22 “(E) SPECIAL RULE FOR RESIDENTS OF
 23 STATES CONTINUING PPACA IMPLEMENTA-
 24 TION.—No credit shall be allowed under this
 25 section to any individual who is not a qualified
 26 resident (as defined in section 100(15) of the

1 Patient Freedom Act of 2017) of a State that
 2 has elected the option under section 102(a)(1)
 3 of such Act in relation to the implementation of
 4 title I of the Patient Protection and Affordable
 5 Care Act.”.

6 (b) LIMITATION ON AMOUNT OF CREDIT.—Section
 7 36B(b) of the Internal Revenue Code of 1986 is amended
 8 by adding at the end the following new paragraph:

9 “(4) LIMITATION ON AMOUNT OF CREDIT.—In
 10 the case of any taxable year beginning in a calendar
 11 year which begins after the date of the enactment of
 12 this paragraph, the Secretary shall reduce the
 13 amount determined under this subsection (deter-
 14 mined before the application of this paragraph) for
 15 each qualified resident (as defined in section 100 of
 16 the Patient Freedom Act of 2017) of a State that
 17 makes an election under section 102(a)(1) of such
 18 Act by an amount equal to—

19 “(A) the amount of the reduction described
 20 in section 102(a)(1)(A) of such Act for such
 21 year (calculated by only taking into account
 22 credit allowed under this section), divided by

23 “(B) the total number of such qualified
 24 residents of such State estimated by the Sec-

1 retary to claim the credit allowed under sub-
2 section (a) for such year.”.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to taxable years beginning after
5 January 1, 2018.

6 **SEC. 212. NEW ROTH HSA CREDIT.**

7 (a) IN GENERAL.—Subpart C of part IV of sub-
8 chapter A of chapter 1 of the Internal Revenue Code of
9 1986 is amended by inserting after section 36B the fol-
10 lowing new section:

11 **“SEC. 36C. ROTH HSA CREDIT.**

12 “(a) IN GENERAL.—In the case of a qualifying indi-
13 vidual, there shall be allowed as a credit against the tax
14 imposed by this subtitle for any taxable year, an amount
15 equal to the Roth HSA credit amount of the individual
16 for the taxable year.

17 “(b) QUALIFYING INDIVIDUAL.—For purposes of this
18 section, the term ‘qualifying individual’ means, with re-
19 spect to any month, any individual who for such month
20 is a deposit qualifying resident (as defined in section
21 103(b)(2) of the Patient Freedom Act of 2017) of a State
22 described in section 102(a)(2) of such Act that elects to
23 have section 103(b) of such Act carried out by way of the
24 credit determined under this section.

1 “(c) ROTH HSA CREDIT AMOUNT.—For purposes of
 2 this section, the term ‘Roth HSA credit amount’ means,
 3 with respect to any taxable year, the sum of the Roth HSA
 4 deposit amounts determined under section 104 of the Pa-
 5 tient Freedom Act of 2017 with respect to the individual
 6 for all months ending during the taxable year.

7 “(d) SPECIAL RULES.—For purposes of this sec-
 8 tion—

9 “(1) RECONCILIATION OF CREDIT AND AD-
 10 VANCE CREDIT.—

11 “(A) EXCESS ADVANCE PAYMENTS.—If the
 12 advance payments to an individual for a taxable
 13 year under subsection (e) exceed the credit al-
 14 lowed by this section with respect to such indi-
 15 vidual for such taxable year, the tax imposed by
 16 this chapter for the taxable year shall be in-
 17 creased by the amount of such excess.

18 “(B) ADVANCE PAYMENT SHORTFALL.—If
 19 the credit allowed by this section (determined
 20 without regard to this subparagraph) with re-
 21 spect to an individual for a taxable year exceeds
 22 the advance payments to such individual for
 23 such taxable year under subsection (e), the Sec-
 24 retary shall, in lieu of a credit allowed against
 25 the tax imposed by this subtitle, make a pay-

1 ment on behalf of such individual to such indi-
 2 vidual's health savings account in an amount
 3 equal to such excess.

4 “(2) MARRIED COUPLES MUST FILE JOINT RE-
 5 TURN.—If the taxpayer is married (within the mean-
 6 ing of section 7703) at the close of the taxable year,
 7 the credit shall be allowed under this section only if
 8 the taxpayer and the taxpayer's spouse file a joint
 9 return for the taxable year.

10 “(e) ADVANCE PAYMENT PROGRAM.—

11 “(1) IN GENERAL.—The Secretary of the
 12 Treasury, in consultation with the Secretary of
 13 Health and Human Services, shall establish a pro-
 14 gram—

15 “(A) to make advance determinations with
 16 respect to the eligibility of individuals for the
 17 credit allowed under this section, and

18 “(B) to make advance payments of the
 19 credit allowed under this section directly to the
 20 Roth HSA of any such individual so eligible.

21 “(2) PROGRAM REQUIREMENTS.—Such pro-
 22 gram shall be established under rules similar to the
 23 rules of section 1412 of the Patient Protection and
 24 Affordable Care Act, except that advance determina-
 25 tions and advance payments shall be made on re-

1 quest of the individual with respect to whom the de-
 2 termination is to be made and taking into account
 3 the enrollment process (including any opt-out elec-
 4 tion under such process) established under section
 5 105(c) of the Patient Freedom Act of 2017.

6 “(3) TREATMENT AS INCOME.—The amount of
 7 any credit allowed under this section shall be in-
 8 cluded in gross income.”.

9 (b) CLERICAL AMENDMENT.—The table of sections
 10 for such subpart is amended by inserting after the item
 11 relating to section 36B the following new item:

“Sec. 36C. Roth HSA credit.”.

12 (c) EFFECTIVE DATE.—The amendments made by
 13 this section shall apply to taxable years beginning after
 14 January 1, 2018.

○