

115TH CONGRESS
1ST SESSION

H. R. 1275

To eliminate the individual and employer health coverage mandates under the Patient Protection and Affordable Care Act, to expand beyond that Act the choices in obtaining and financing affordable health insurance coverage, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 1, 2017

Mr. SESSIONS introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To eliminate the individual and employer health coverage mandates under the Patient Protection and Affordable Care Act, to expand beyond that Act the choices in obtaining and financing affordable health insurance coverage, and for other purposes.

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

1 **SECTION 1. SHORT TITLE; PURPOSES; TABLE OF CON-**
 2 **TENTS.**

3 (a) **SHORT TITLE.**—This Act may be cited as the
 4 “World’s Greatest Healthcare Plan of 2017”.

5 (b) **PURPOSES.**—The purposes of this Act are as fol-
 6 lows:

7 (1) **ELIMINATION OF INDIVIDUAL AND EM-**
 8 **PLOYER MANDATES UNDER ACA.**—To eliminate man-
 9 dates on individuals and employers, and other tax
 10 requirements, imposed under Patient Protection and
 11 Affordable Care Act.

12 (2) **PROVIDING STATES WITH ALTERNATIVE,**
 13 **AFFORDABLE COVERAGE OPTIONS.**—To provide
 14 greater flexibility in providing States with options in
 15 making affordable health insurance coverage avail-
 16 able by eliminating certain mandates under PPACA,
 17 while retaining essential consumer protections, by
 18 promoting health savings accounts to pay for such
 19 coverage and long-term care coverage, while permit-
 20 ting States to continue coverage as provided under
 21 PPACA.

22 (c) **TABLE OF CONTENTS.**—The table of contents of
 23 this Act is as follows:

Sec. 1. Short title; purposes; table of contents.

Sec. 2. Definitions.

TITLE I—REVISIONS OF PPACA

Subtitle A—Elimination of Individual and Employer Mandates

- Sec. 101. Repeal of individual health insurance mandate.
- Sec. 102. Repeal of employer health insurance mandate.
- Sec. 103. Clarifying employer's ability to reimburse employee premiums for purchase of individual health insurance coverage.

Subtitle B—Limitation on Application of PPACA Plan Requirements

- Sec. 121. Limiting application of requirements to consumer protections.
- Sec. 122. Offering of basic health insurance; protection of assets from liability or attachment or seizure.

Subtitle C—Health Insurance Tax Benefit

- Sec. 131. Health insurance tax benefit.
- Sec. 132. Application of portion of unused tax credits by States for indigent health care.
- Sec. 133. Medicaid option of enrollment under private plan and contribution to an HSA.

TITLE II—IMPROVING HEALTH SAVINGS ACCOUNTS TO PROMOTE ACCOUNTABILITY

- Sec. 201. Transition to non-deductible HSAs.
- Sec. 202. Elimination of medical expense deduction.
- Sec. 203. Treatment of HSA after death of account beneficiary.
- Sec. 204. Treatment of concierge medicine.

TITLE III—STATE FLEXIBILITY IN REGULATION OF HEALTH INSURANCE COVERAGE

- Sec. 301. State flexibility in regulation of health insurance coverage.

TITLE IV—MEDICAID PAYMENT REFORM

- Sec. 401. Medicaid payment reform.

TITLE V—INCREASING PRICE TRANSPARENCY AND FREEDOM OF PRACTICE

- Sec. 501. Ensuring access to emergency services without excessive charges for out-of-network services.
- Sec. 502. Publishing of cash price for care paid through health savings accounts.
- Sec. 503. Liberating the local practice of health care.

1 **SEC. 2. DEFINITIONS.**

2 Except as otherwise provided, in this Act:

- 3 (1) BASIC HEALTH INSURANCE.—The term
- 4 “basic health insurance” is defined in section
- 5 122(a).

1 (2) DEFAULT HEALTH INSURANCE COV-
2 ERAGE.—The term “default health insurance cov-
3 erage” is defined in section 121(b)(4)(B).

4 (3) EXCHANGE.—The term “Exchange” means
5 an Exchange established under title I of PPACA.

6 (4) HEALTH INSURANCE COVERAGE; GROUP
7 HEALTH PLAN, ETC.—The terms defined in section
8 2791 of the Public Health Service Act, including
9 “health insurance coverage”, “group health plan”
10 “individual market”, shall apply.

11 (5) LIMITED BENEFIT INSURANCE.—The term
12 “limited benefit insurance” is defined in section
13 122(b).

14 (6) PPACA.—The term “PPACA” means the
15 Patient Protection and Affordable Care Act (Public
16 Law 111–148).

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

19 (8) STATE.—The term “State” includes the
20 District of Columbia, Puerto Rico, the United States
21 Virgin Islands, American Samoa, Guam, and the
22 Northern Mariana Islands.

1 **TITLE I—REVISIONS OF PPACA**
 2 **Subtitle A—Elimination of**
 3 **Individual and Employer Mandates**

4 **SEC. 101. REPEAL OF INDIVIDUAL HEALTH INSURANCE**
 5 **MANDATE.**

6 Section 5000A of the Internal Revenue Code of 1986
 7 is amended by adding at the end the following new sub-
 8 section:

9 “(h) TERMINATION.—This section shall not apply
 10 with respect to any month beginning more than 30 days
 11 after the date of the enactment of the World’s Greatest
 12 Healthcare Plan of 2017.”.

13 **SEC. 102. REPEAL OF EMPLOYER HEALTH INSURANCE MAN-**
 14 **DATE.**

15 (a) IN GENERAL.—Chapter 43 of the Internal Rev-
 16 enue Code of 1986 is amended—

17 (1) by striking section 4980H; and

18 (2) by striking the item relating to section
 19 4980H from the table of sections for such chapter.

20 (b) REPEAL OF RELATED REPORTING REQUIRE-
 21 MENTS.—Subpart D of part III of subchapter A of chap-
 22 ter 61 of such Code is amended by striking section 6056
 23 and by striking the item relating to section 6056 in the
 24 table of sections for such subpart.

25 (c) CONFORMING AMENDMENTS.—

1 (1) Section 6724(d)(1)(B) of such Code is
2 amended—

3 (A) by inserting “or” at the end of clause
4 (xxiii);

5 (B) by striking “, or” at the end of clause
6 (xxiv) and inserting a period; and

7 (C) by striking clause (xxv).

8 (2) Section 6724(d)(2) of such Code is amend-
9 ed by inserting “or” at the end of subparagraph
10 (FF), by striking “, or” at the end of subparagraph
11 (GG) and inserting a period, and by striking sub-
12 paragraph (HH).

13 (3) Section 1513 of the Patient Protection and
14 Affordable Care Act is amended by striking sub-
15 section (c).

16 (d) EFFECTIVE DATES.—

17 (1) IN GENERAL.—Except as otherwise pro-
18 vided in this subsection, the amendments made by
19 this section shall apply to months and other periods
20 beginning more than 30 days after the date of the
21 enactment of this Act.

22 (2) REPEAL OF STUDY AND REPORT.—The
23 amendment made by subsection (c)(3) shall take ef-
24 fect on the date of the enactment of this Act.

1 **SEC. 103. CLARIFYING EMPLOYER'S ABILITY TO REIM-**
2 **BURSE EMPLOYEE PREMIUMS FOR PUR-**
3 **CHASE OF INDIVIDUAL HEALTH INSURANCE**
4 **COVERAGE.**

5 An employer health care arrangement, such as a
6 health or medical reimbursement arrangement (HRA) or
7 other employment plans, under which an employer reim-
8 burses an employee for the premiums for the purchase of
9 individual health insurance coverage does not constitute
10 a group health plan for any purposes, including for pur-
11 poses of applying any of the following:

12 (1) The Public Health Service Act (including
13 sections 2711 and 2714 of such Act, 42 U.S.C.
14 300gg-11, 300gg-14).

15 (2) The Patient Protection and Affordable Care
16 Act.

17 (3) The Internal Revenue Code of 1986.

18 (4) The Employee Retirement Income Security
19 Act of 1974.

20 (5) The HIPAA privacy regulations (as defined
21 in section 1180(b)(3) of the Social Security Act, 42
22 U.S.C. 1320d-9(b)(3)).

23 (6) The Health Insurance Portability and Ac-
24 countability Act of 1996.

25 (7) COBRA continuation coverage under title
26 XXII of the Public Health Service Act (42 U.S.C.

1 300bb–1 et seq.), section 4980B of the Internal Rev-
 2 enue Code of 1986, or title VI of the Employee Re-
 3 tirement Income Security Act of 1974 (29 U.S.C.
 4 1161 et seq.).

5 **Subtitle B—Limitation on Applica-**
 6 **tion of PPACA Plan Require-**
 7 **ments**

8 **SEC. 121. LIMITING APPLICATION OF REQUIREMENTS TO**
 9 **CONSUMER PROTECTIONS.**

10 (a) REMOVAL OF PPACA PLAN REQUIREMENTS,
 11 OTHER THAN CERTAIN CONSUMER PROTECTIONS.—

12 (1) IN GENERAL.—Notwithstanding any other
 13 provision of law, with respect to group health plans
 14 and health insurance coverage whether or not of-
 15 fered through an Exchange, except as provided in
 16 paragraphs (2) and (3), the provisions of title
 17 XXVII of the Public Health Service Act (42 U.S.C.
 18 300gg et seq.) as in effect on the day before the date
 19 of the enactment of PPACA shall apply instead of
 20 the provisions of such title as in effect after such
 21 date.

22 (2) PPACA CONSUMER PROTECTIONS CON-
 23 TINUING TO BE APPLIED.—The following sections of
 24 the Public Health Service Act, that were added or
 25 amended by subtitles A and C of title I of PPACA,

1 shall continue to apply to group health plans and to
2 health insurance coverage offered in the individual
3 and group market:

4 (A) NO LIFETIME OR ANNUAL LIMITS.—

5 Section 2711 (42 U.S.C. 300gg-11; relating to
6 no lifetime or annual limits), except in the case
7 of limited benefit insurance (as defined in sec-
8 tion 122(b)).

9 (B) DEPENDENT COVERAGE THROUGH

10 AGE 26.—Section 2714 (42 U.S.C. 300bb-14;
11 relating to extension of dependent coverage).

12 (C) MODIFIED GUARANTEED AVAIL-

13 ABILITY.—Section 2702 (42 U.S.C. 300gg-1;
14 relating to guaranteed availability of coverage),
15 subject to paragraph (3) and subsection (c).

16 (D) GUARANTEED RENEWABILITY.—Sec-

17 tion 2703 (42 U.S.C. 300gg-2; relating to
18 guaranteed renewability of coverage).

19 (E) PROHIBITING PRE-EXISTING CONDI-

20 TION EXCLUSIONS.—Section 2704 (42 U.S.C.
21 300gg-3; relating to prohibition on preexisting
22 conditions).

23 (F) PROHIBITING DISCRIMINATION BASED

24 ON HEALTH STATUS.—Section 2705 (42 U.S.C.
25 300gg-4; relating to prohibiting discrimination

1 against individual participants and beneficiaries
2 based on health status), subject to subsection
3 (c).

4 (G) NON-DISCRIMINATION IN HEALTH
5 CARE.—Section 2706 (42 U.S.C. 300gg–5; re-
6 lating to non-discrimination in health care).

7 (3) APPLICATION OF A LATE ENROLLMENT
8 PENALTY FOR THOSE WITHOUT CONTINUOUS COV-
9 ERAGE.—

10 (A) IN GENERAL.—In the case of an indi-
11 vidual who seeks to enroll in health insurance
12 coverage and who, as of the effective date of
13 such enrollment, does not have a continuous pe-
14 riod of at least 12 months of creditable cov-
15 erage, there shall be imposed a late enrollment
16 penalty in the form of an increase in the
17 monthly premiums for coverage of under the
18 plan of 20 percent of the monthly premium oth-
19 erwise determined for each consecutive full 12-
20 month period (ending before such effective
21 date) in which the individual was not enrolled
22 in creditable coverage. Such increase shall apply
23 during a period, to be specified under regula-
24 tions of the Secretary but in no case longer
25 than 3 times the length of the most recent pe-

1 riod in which the individual did not have contin-
2 uous coverage.

3 (B) STATE WAIVER.—A State may apply
4 to the Secretary for a waiver of the provisions
5 of subparagraph (A) and the application of al-
6 ternative provisions providing incentives for
7 State residents to enroll in creditable coverage
8 and maintain continuous creditable coverage.
9 The Secretary shall approve such waiver if the
10 Secretary determines that the alternative provi-
11 sions provide similar or greater incentives for
12 such enrollment than the incentives otherwise
13 applicable.

14 (4) COORDINATING IMPLEMENTATION OF PRE-
15 PPACA PHSA PROVISIONS WITH PPACA CONSUMER
16 PROTECTIONS.—

17 (A) IN GENERAL.—In applying this sub-
18 section, the provisions described in paragraph
19 (2) shall be treated as if they were included in
20 title XXVII of the Public Health Service Act,
21 as in effect before the date of enactment of
22 PPACA, and, with respect to group health
23 plans and health insurance coverage offered in
24 connection with such plans, in part 7 of subtitle
25 B of title I of the Employee Retirement and In-

1 come Security Act of 1974 (29 U.S.C. 1181 et
2 seq.), and, with respect to group health plans,
3 in chapter 100 of the Internal Revenue Code of
4 1986 as follows:

5 (i) LIFETIME LIMITS; DEPENDENT
6 COVERAGE.—The provisions described in
7 paragraphs (2)(A) and (2)(B) shall be
8 treated as included—

9 (I) with respect to group health
10 plans (and health insurance coverage
11 offered with respect to such plans),
12 under subpart 2 of part A of title
13 XXVII of the Public Health Service
14 Act (42 U.S.C. 300gg–11 et seq.) and
15 subpart B of part 7 of subtitle B of
16 title I of the Employee Retirement
17 and Income Security Act of 1974 (29
18 U.S.C. 1181 et seq.);

19 (II) also with respect to group
20 health plans, under subchapter B of
21 chapter 100 of the Internal Revenue
22 Code of 1986; and

23 (III) with respect to individual
24 health insurance coverage, under sub-
25 part 2 of part B of title XXVII of the

1 Public Health Service Act (42 U.S.C.
2 300gg–15 et seq.).

3 (ii) REMAINING PROVISIONS.—The
4 provision described in paragraph (2) (other
5 than in subparagraph (A) or (B) of such
6 paragraph) shall be treated as included—

7 (I) with respect to group health
8 plans (and health insurance coverage
9 offered with respect to such plans),
10 under subpart 1 of part A of title
11 XXVII of the Public Health Service
12 Act (42 U.S.C. 300gg et seq.) and
13 subpart A of part 7 of subtitle B of
14 title I of the Employee Retirement
15 and Income Security Act of 1974 (29
16 U.S.C. 1181 et seq.);

17 (II) also with respect to group
18 health plans, under subchapter A of
19 chapter 100 of the Internal Revenue
20 Code of 1986; and

21 (III) with respect to individual
22 health insurance coverage, under sub-
23 part 1 of part B of title XXVII of the
24 Public Health Service Act (42 U.S.C.
25 300gg–41 et seq.).

1 (B) CONFLICTING PROVISIONS.—In the
2 case described in paragraph (1) where there is
3 a conflict between a provision described in para-
4 graph (2) and a provision of law described in
5 paragraph (1), the provision described in para-
6 graph (2) shall control and the Secretary, in
7 consultation with the Secretary of the Treasury
8 and the Secretary of Labor, shall establish such
9 rules as may be necessary to carry out this sub-
10 paragraph.

11 (5) CONFORMING AMENDMENTS.—

12 (A) ERISA.—Section 715 of the Employee
13 Retirement Income Security Act of 1974 (29
14 U.S.C. 1185d) is amended—

15 (i) in subsection (a), by striking “sub-
16 section (b)” and inserting “subsections (b)
17 and (c)”; and

18 (ii) by adding at the end the following
19 new subsection:

20 “(c) ADDITIONAL EXCEPTION.—Pursuant to section
21 121 of the World’s Greatest Healthcare Plan of 2017, the
22 provisions of part A of title XXVII of the Public Health
23 Service Act referred to in subsection (a), other than those
24 provisions specified in section 121(a)(2) of the World’s
25 Greatest Healthcare Plan of 2017, shall not apply to plans

1 and coverage described in subsection (a), whether or not
 2 the plans or coverage are offered through an Exchange
 3 established under the Patient Protection and Affordable
 4 Care Act.”.

5 (B) IRC.—Section 9815 of the Internal
 6 Revenue Code of 1986 is amended—

7 (i) in subsection (a), by striking “sub-
 8 section (b)” and inserting “subsections (b)
 9 and (c)”; and

10 (ii) by adding at the end the following
 11 new subsection:

12 “(c) ADDITIONAL EXCEPTION.—Pursuant to section
 13 121 of the World’s Greatest Healthcare Plan of 2017, the
 14 provisions of part A of title XXVII of the Public Health
 15 Service Act referred to in subsection (a), other than those
 16 provisions specified in section 121(a)(2) of the World’s
 17 Greatest Healthcare Plan of 2017, shall not apply to plans
 18 described in subsection (a).”.

19 (b) STATE FLEXIBILITY IN ENSURING ORDERLY
 20 HEALTH INSURANCE MARKET OUTSIDE OF AN EX-
 21 CHANGE.—

22 (1) IN GENERAL.—With respect to health insur-
 23 ance coverage offered in a State, the State may, in
 24 consultation with the Secretary, take such steps,
 25 such as limiting the availability of general open en-

1 rollment periods, imposing delays in the effectiveness
2 for coverage, permitting differentials in premiums
3 based on age and other factors, as the State deter-
4 mines necessary in order to ensure an orderly mar-
5 ket for health insurance coverage in the State that
6 is not offered through an Exchange. Such steps may
7 include the establishment of such initial open enroll-
8 ment period during which qualified residents may
9 enroll in health insurance coverage without the im-
10 position of any underwriting as the State determines
11 to be appropriate in ensuring initial access to such
12 coverage.

13 (2) FLEXIBILITY IN IMPOSING ADDITIONAL RE-
14 QUIREMENTS.—Subject to paragraph (5), nothing in
15 this section shall be construed as preventing a State
16 from continuing to apply, to health insurance cov-
17 erage issued in the State, requirements under the
18 provisions of title XXVII of the Public Health Serv-
19 ice Act (as amended by subtitles A and C of title I
20 of PPACA) that are not continued under subsection
21 (a).

22 (3) STATE FLEXIBILITY WITH RESPECT TO EX-
23 CHANGES.—A State may waive such provisions of
24 part II of subtitle D of title I of PPACA (42 U.S.C.
25 18031 et seq.), in relation to the establishment of an

1 Exchange in such State, as the State determines ap-
2 propriate in order for the State to implement and
3 administer a market-based system for the avail-
4 ability of health insurance coverage throughout the
5 State.

6 (4) STATE DEFAULT ENROLLMENT OPTION.—

7 (A) ENROLLMENT, SUBJECT TO INDI-
8 VIDUAL OPT-OUT.—Subject to subparagraph
9 (D), a State may elect to provide for the enroll-
10 ment of residents of the State who are unin-
11 sured in default health insurance coverage (as
12 defined in subparagraph (B)) and establishing a
13 Roth HSA for such residents who do not have
14 a Roth HSA unless the resident has affirma-
15 tively elected not to be so enrolled and not to
16 have such an account. respectively. If a State
17 makes such an election, the State shall permit
18 eligible residents to enroll in such coverage on
19 a continuous basis.

20 (B) DEFAULT HEALTH INSURANCE COV-
21 ERAGE DEFINED.—In this paragraph, the term
22 “default health insurance coverage” means,
23 with respect to a State, health insurance cov-
24 erage that—

1 (i) is a high deductible health plan
2 (within the meaning of section 223(c)(2) of
3 the Internal Revenue Code of 1986) with
4 prescription drug coverage limited to ge-
5 neric drugs for a limited number of chronic
6 conditions (commonly referred to as tier I
7 pharmacy benefit);

8 (ii) meets such requirements as may
9 apply to qualify for the payment of plan
10 premiums from a health savings account
11 under section 223 of such Code (such as
12 age-related premiums and limitation on
13 imposition of preexisting condition exclu-
14 sions);

15 (iii) has a provider network for cov-
16 ered benefits that is adequate (as deter-
17 mined consistent with guidelines issued by
18 the Secretary) to ensure access to health
19 benefits under such plan;

20 (iv) provides for coverage of childhood
21 immunizations without cost sharing re-
22 quirements to the extent such immuniza-
23 tions have in effect a recommendation
24 from the Advisory Committee on Immuni-
25 zation Practices of the Centers for Disease

1 Control and Prevention with respect to the
2 individual involved; and

3 (v) meets such other requirements as
4 the State may specify.

5 (C) ROTH HSA.—In this paragraph, the
6 term “Roth HSA” shall have the meaning given
7 such term by section 530A(c) of the Internal
8 Revenue Code of 1986, as added by section
9 201(a) of this Act.

10 (D) SIMPLE PROCESS FOR INDIVIDUALS TO
11 OPT-OUT.—As a condition of a State providing
12 for the enrollment function described in sub-
13 paragraph (A), the State must establish an
14 easy-to-use and transparent means by which in-
15 dividuals may elect not to be enrolled in default
16 health insurance coverage or to have a Roth
17 HSA established on the individual’s behalf, or
18 both.

19 (5) MINIMUM AGE VARIATION PERMITTED FOR
20 PREMIUM RATES.—With respect to the premium rate
21 charged by a health insurance issuer for health in-
22 surance coverage offered in the individual or small
23 group market, a State may not limit the variation by
24 age in such rate with respect to a particular plan or
25 coverage involved by less than a factor of 5 to 1 for

1 adults. The previous sentence shall be treated as if
 2 it were included in subpart I of part A of title
 3 XXVII of the Public Health Service Act (42 U.S.C.
 4 300gg et seq.).

5 (c) INAPPLICABILITY OF REQUIRED ESSENTIAL
 6 HEALTH BENEFITS.—

7 (1) IN GENERAL.—Notwithstanding any other
 8 provision of law, no health benefits plan shall be re-
 9 quired by reason of Federal law to comply with the
 10 requirements of sections 1301(a)(1)(B) and 1302 of
 11 PPACA (42 U.S.C. 18021(a)(1)(B), 18022).

12 (2) STATE FLEXIBILITY.—Nothing in this sub-
 13 section shall be construed as preventing a State
 14 from applying, at its option with respect to health
 15 insurance coverage offered through an Exchange or
 16 otherwise in the State, the requirements referred to
 17 in paragraph (1).

18 (d) EFFECTIVE DATE; TRANSITION.—

19 (1) IN GENERAL.—Subsection (a), (b), and (c)
 20 shall apply to plan years beginning after the date of
 21 the enactment of this Act.

22 (2) SUNSETTING REQUIRED CONTRIBUTION FOR
 23 ACA REINSURANCE PROGRAM.—No contribution shall
 24 be required under section 1341 of PPACA (42
 25 U.S.C. 18061) from any group health plan or health

1 insurance issuer for portions of plans years occur-
2 ring in months beginning more than 30 days after
3 the date of the enactment of this Act.

4 (e) SECRETARIAL GUIDANCE.—The Secretary of
5 Health and Human Services, in coordination with the Sec-
6 retary of Labor and the Secretary of the Treasury, shall
7 provide such guidance as may be necessary for the coordi-
8 nated implementation of this section on a timely basis.

9 (f) TRANSFERRING HEALTH PLAN RECORDS UPON
10 CHANGING PLANS.—

11 (1) IN GENERAL.—In the case of an individual
12 who is covered under health insurance coverage or as
13 a beneficiary or participant in a group health plan
14 (as such terms are defined in section 2791 of the
15 Public Health Service Act, 42 U.S.C. 300gg–91), if
16 such coverage is ended and the individual obtains
17 other health insurance coverage, group health plan
18 coverage, or other creditable coverage (as defined for
19 purposes of title XXVII of such Act), the issuer of
20 the prior coverage or administrator of the prior plan
21 shall forward information respecting such prior cov-
22 erage to the issuer of the new coverage or adminis-
23 trator of the new plan or coverage, as the case may
24 be, subject to such rules as the Secretary establishes

1 regarding the right of the beneficiary or participant
2 to object to such forwarding of information.

3 (2) TREATMENT AS PLAN REQUIREMENT
4 UNDER PHSA, ERISA, IRC.—The requirement of
5 paragraph (1) shall apply as if it were a section
6 under part A of title XXVII of the Public Health
7 Service Act, including for purposes of applying sec-
8 tion 715 of the Employee Retirement Income Secu-
9 rity Act of 1976 (29 U.S.C. 1185d) and section
10 9815 of the Internal Revenue Code of 1986.

11 (g) APPLICATION OF RISK ADJUSTMENT.—

12 (1) IN GENERAL.—Any issuer that offers health
13 insurance coverage in the individual market in any
14 of the 50 States or the District of Columbia shall
15 participate in a risk adjustment mechanism under
16 this subsection with respect to any health insurance
17 coverage it so offers in such market, whether or not
18 such coverage is offered through an Exchange.

19 (2) FORM AND DESIGN OF RISK ADJUSTMENT
20 MECHANISM.—The Secretary shall, in consultation
21 with the National Association of Insurance Commis-
22 sioners and other interested parties, develop a mech-
23 anism to permit the adjustment of risk among
24 health insurance coverage offered in the individual
25 market throughout the 50 States and the District of

1 Columbia. Such mechanism shall be designed to ef-
2 fect the same type of risk adjustment among such
3 coverage that is applicable to risk adjustment of
4 payments among Medicare Advantage organizations
5 under part C of title XVIII of the Social Security
6 Act (42 U.S.C. 1395w–21 et seq.).

7 (3) TRANSITION FOR NEW COVERAGE.—The
8 mechanism developed under paragraph (2) shall pro-
9 vide for transitional protection, over a 3-year period,
10 in the case of health insurance coverage that has not
11 been previously marketed.

12 (4) DEVELOPMENT OF FURTHER RISK ADJUST-
13 MENT MECHANISM.—The Secretary shall request the
14 National Association of Insurance Commissioners to
15 develop a permanent model for adjustment of risk
16 among health insurance issuers with respect to
17 health insurance coverage offered in the individual
18 market, with the intention that such a model would
19 substitute for the mechanism developed under para-
20 graph (2).

21 (5) TREATMENT AS PLAN REQUIREMENT
22 UNDER PHSA, ERISA, IRC.—The requirement of
23 paragraph (1) shall apply as if it were a section
24 under part A of title XXVII of the Public Health
25 Service Act (42 U.S.C. 300gg et seq.), including for

1 purposes of applying section 715 of the Employee
 2 Retirement Income Security Act of 1976 (29 U.S.C.
 3 1185d) and section 9815 of the Internal Revenue
 4 Code of 1986.

5 **SEC. 122. OFFERING OF BASIC HEALTH INSURANCE; PRO-**
 6 **TECTION OF ASSETS FROM LIABILITY OR AT-**
 7 **TACHMENT OR SEIZURE.**

8 (a) REQUIREMENT FOR EXCHANGES.—

9 (1) IN GENERAL.—No tax credit shall be allow-
 10 able under section 36B or 36C of the Internal Rev-
 11 enue Code of 1986 for residents of a State unless
 12 any Exchange established in the State provides for
 13 the offering of basic health insurance in all areas of
 14 the State.

15 (2) BASIC HEALTH INSURANCE DEFINED.—In
 16 this subsection, the term “basic health insurance”
 17 means, with respect to a State, such health insur-
 18 ance coverage as the State may specify and includes
 19 limited benefit insurance (as defined in subsection
 20 (b)).

21 (b) LIMITED BENEFIT INSURANCE DEFINED.—

22 (1) IN GENERAL.—In this title, the term “lim-
 23 ited benefit insurance” means individual health in-
 24 surance coverage that, with respect to a plan year,
 25 imposes (consistent with paragraph (2)) an annual

1 limit on the amounts that may be payable under the
2 coverage with respect to expenses incurred for items
3 and services furnished in that plan year.

4 (2) SPECIFICATION OF ANNUAL LIMIT; VARI-
5 ATION IN LIMIT FOR INDIVIDUAL AND FAMILY COV-
6 ERAGE.—The Secretary shall specify, from year to
7 year, the annual limit (or range of annual limits)
8 that may be applied under paragraph (1). Such a
9 limit may distinguish between coverage that is only
10 provided for an individual and coverage that is pro-
11 vided also for family members of the individual.

12 (c) PROTECTION OF CERTAIN ASSETS IN CASE OF
13 INDIVIDUALS COVERED UNDER LIMITED BENEFIT IN-
14 SURANCE.—

15 (1) IN GENERAL.—Notwithstanding any other
16 provision of law, if an individual is covered under
17 limited benefit insurance for a plan year and bene-
18 fits under such insurance have reached the annual
19 limit under such insurance for items and services
20 furnished in the plan year, the individual is not lia-
21 ble for debt incurred and arising from the provision
22 of subsequently furnished items and services during
23 the plan year, regardless of whether benefits are oth-
24 erwise covered for such items and services under

1 such policy, insofar as the liability attributable to
2 such items and services exceeds—

3 (A) the bankruptcy valuation of the indi-
4 vidual's property at the time the debt is in-
5 curred; reduced by

6 (B) such annual limit of benefits under the
7 limited benefit insurance for the plan year.

8 Property in the amount so protected from liability
9 shall be exempt and immune from attachment or sei-
10 zure with respect to any judgment related to such
11 debt.

12 (2) BANKRUPTCY VALUATION DEFINED.—In
13 this subsection, the term “bankruptcy valuation”
14 means, with respect to property of an individual as
15 of a date, the value of the property as of such date
16 as determined as if the individual were a debtor in
17 a bankruptcy case that could have been filed under
18 title 11 of the United States Code and the property
19 could not be exempt under section 522 of such title.

20 (3) NO REQUIREMENT FOR PROVIDERS TO FUR-
21 NISH SUBSEQUENT SERVICES WITHOUT ENSURING
22 PAYMENT.—Except as may be explicitly provided in
23 other law (such as under section 1867 of the Social
24 Security Act, 42 U.S.C. 1395dd; popularly known as
25 EMTALA), a health care provider is not required to

1 furnish any items or services to an individual who
 2 has exhausted benefits under limited benefit insur-
 3 ance for a plan year without the individual (or an-
 4 other person on the individual’s behalf) providing for
 5 such advance or guarantee of payment for such
 6 items and services as may be arranged between the
 7 health care provider and the individual.

8 **Subtitle C—Health Insurance Tax** 9 **Benefit**

10 **SEC. 131. HEALTH INSURANCE TAX BENEFIT.**

11 (a) IN GENERAL.—Subpart C of part IV of sub-
 12 chapter A of chapter 1 of the Internal Revenue Code of
 13 1986 is amended by inserting after section 36B the fol-
 14 lowing new section:

15 **“SEC. 36C. HEALTH INSURANCE TAX CREDIT.**

16 “(a) IN GENERAL.—In the case of an individual who
 17 is a qualified resident, there shall be allowed as a credit
 18 against the tax imposed by this subtitle for any taxable
 19 year an amount equal to the health credit amount of the
 20 taxpayer for the taxable year.

21 “(b) HEALTH CREDIT AMOUNT.—For purposes of
 22 this section—

23 “(1) IN GENERAL.—The term ‘health credit
 24 amount’ means the sum of the amounts determined

1 under paragraph (2) with respect to all months of
2 the taxpayer for the taxable year.

3 “(2) MONTHLY CREDIT AMOUNT.—

4 “(A) IN GENERAL.—Subject to paragraph
5 (4), the amount determined under this para-
6 graph with respect to any month shall be an
7 amount equal to the sum of—

8 “(i) $\frac{1}{12}$ of \$2,500 in the case of any
9 month the first day of which the taxpayer
10 is a qualified resident and is covered by
11 creditable coverage (twice such amount in
12 the case of a joint return if both spouses
13 are so covered by creditable coverage and
14 are qualified residents), plus

15 “(ii) $\frac{1}{12}$ of an amount equal to
16 \$1,500 multiplied by the number of quali-
17 fying children (within the meaning of sec-
18 tion 152) who are qualified residents
19 and—

20 “(I) for whom the taxpayer is al-
21 lowed a deduction under section 151
22 for the taxable year in which such
23 month ends, and

1 “(II) who are covered by cred-
2 itable coverage on the first day of
3 such month.

4 “(B) CARRYFORWARD OF MONTHLY CRED-
5 IT AMOUNT IN CASE CREDIT AMOUNT EXCEEDS
6 HSA CONTRIBUTIONS AND PREMIUM PAY-
7 MENTS.—In the case of any month for which
8 the credit amount determined with respect to
9 the taxpayer under subparagraph (A) exceeds
10 the limitation amount determined with respect
11 to the taxpayer for such month under para-
12 graph (3), such excess may be carried forward
13 to any subsequent month during the taxable
14 year for purposes of determining the credit
15 amount for such month under this paragraph.

16 “(3) MONTHLY LIMITATION.—

17 “(A) IN GENERAL.—The amount deter-
18 mined under paragraph (2) for any month of
19 the taxpayer shall not exceed the sum of—

20 “(i) the amounts contributed to a
21 health savings account of the taxpayer for
22 such month, plus

23 “(ii) the premiums paid by the tax-
24 payer for creditable coverage.

1 “(B) CARRYFORWARD OF MONTHLY LIM-
2 TATION IN CASE HSA CONTRIBUTIONS AND PRE-
3 MIUM PAYMENTS EXCEED MONTHLY CREDIT
4 AMOUNT.—In the case of any month for which
5 the amount determined with respect to the tax-
6 payer under subparagraph (A) exceeds the cred-
7 it amount determined with respect to the tax-
8 payer for such month under paragraph (2),
9 such excess may be carried forward to any sub-
10 sequent month during the taxable year for pur-
11 poses of determining the limitation under sub-
12 paragraph (A).

13 “(4) ADJUSTMENT FOR LIMITED BENEFIT IN-
14 SURANCE.—In the case of a taxpayer whose only
15 health insurance coverage for a month is limited
16 benefit insurance (as defined in section 123(b) of the
17 World’s Greatest Healthcare Plan of 2017), the
18 amount determined under paragraph (2) shall be de-
19 creased by such proportion as the Secretary, in con-
20 sultation with the Secretary of Health and Human
21 Services, determines appropriate, taking into ac-
22 count the ratio of the actuarial value of such limited
23 benefit insurance to the average actuarial value of
24 health insurance coverage that is not limited benefit
25 insurance.

1 “(5) ADJUSTMENT FOR GEOGRAPHIC AREA AND
 2 AGE OF COVERED INDIVIDUAL.—The amount deter-
 3 mined under paragraph (2) shall be adjusted, in a
 4 manner specified by the Secretary, in consultation
 5 with and based on data collected by the Secretary of
 6 Health and Human Services, to take into account,
 7 for a taxpayer or other covered individual of an age
 8 and residing in an area, the ratio of the average cost
 9 of typical individual health insurance coverage for an
 10 individual of such age and residing in such area to
 11 the national average cost of such typical health in-
 12 surance coverage. Such adjustment shall be made in
 13 a manner so that the application of this paragraph
 14 is estimated not to change the aggregate amount of
 15 the credits allowable under this section for taxable
 16 years ending in a year.

17 “(c) COORDINATION WITH EMPLOYER-PROVIDED
 18 HEALTH INSURANCE TAX SUBSIDY.—

19 “(1) CREDIT LIMITED BY EMPLOYER-PROVIDED
 20 HEALTH INSURANCE TAX SUBSIDY.—The credit al-
 21 lowed under this section for any taxable year shall
 22 not exceed an amount equal to the excess (if any)
 23 of—

24 “(A) the maximum credit which would be
 25 allowed for all months of the taxpayer during

1 the taxable year (determined under subsection
 2 (b)(2) and without regard to this subsection,
 3 the limitation under subsection (b)(3), and any
 4 reduction under subsection (d)(1)), over

5 “(B) the taxpayer’s employer-provided
 6 health insurance tax subsidy for the taxable
 7 year.

8 “(2) EMPLOYER-PROVIDED HEALTH INSURANCE
 9 TAX SUBSIDY.—For purposes of this subsection—

10 “(A) IN GENERAL.—The term ‘employer-
 11 provided health insurance tax subsidy’ means,
 12 with respect to any taxpayer for a taxable year,
 13 the sum of—

14 “(i) the Federal income tax subsidy of
 15 the taxpayer for the taxable year, plus

16 “(ii) the Federal payroll tax subsidy
 17 of the taxpayer for the taxable year.

18 “(B) FEDERAL INCOME TAX SUBSIDY.—
 19 The term ‘Federal income tax subsidy’ means,
 20 with respect to any taxpayer for the taxable
 21 year, the excess (if any) of—

22 “(i) the amount of tax that would
 23 have been imposed by this chapter for the
 24 taxable year had such tax been determined
 25 without regard to this section and by in-

cluding amounts otherwise excluded from gross income which were paid by or on behalf of the taxpayer for employer-provided insurance that constitutes medical care, over

“(ii) the amount of tax imposed by this chapter for the taxable year (determined without regard to this section).

“(C) FEDERAL PAYROLL TAX SUBSIDY.—

The term ‘Federal payroll tax subsidy’ means, with respect to any taxpayer for the taxable year, the excess (if any) of—

“(i) the sum of—

“(I) the amount of tax that would have been imposed by chapter 21 with respect to any wages of the taxpayer paid during the taxable year had such tax been determined by including amounts otherwise excluded from wages which were paid by or on behalf of the taxpayer during the taxable year for employer-provided insurance that constitutes medical care, plus

1 “(II) the amount of tax that
2 would have been imposed by chapter 2
3 on any self-employment income of the
4 taxpayer for such taxable year had
5 self-employment income been deter-
6 mined without regard to any deduc-
7 tion from gross income for amounts
8 paid for insurance which constitutes
9 medical care for the taxpayer, the tax-
10 payer’s spouse, and any qualifying
11 children (within the meaning of sec-
12 tion 152) for whom the taxpayer is al-
13 lowed a deduction under section 151
14 for the taxable year, over

15 “(ii) the amount of tax imposed with
16 respect to the taxpayer during such taxable
17 year under chapter 21 and for such taxable
18 year under chapter 2.

19 “(d) RECONCILIATION OF CREDIT AND ADVANCE
20 CREDIT.—

21 “(1) IN GENERAL.—The amount of the credit
22 allowed under this section for any taxable year (after
23 the application of subsections (b) and (c)) shall be
24 reduced (but not below zero) by the amount of any

1 advance payment of such credit under subsection
2 (e)(1).

3 “(2) EXCESS ADVANCE PAYMENTS.—

4 “(A) IN GENERAL.—If the advance pay-
5 ments to a taxpayer under subsection (e)(1) for
6 a taxable year exceed the credit allowed by this
7 section (determined without regard to para-
8 graph (1)), the tax imposed by this chapter for
9 the taxable year shall be increased by the
10 amount of such excess.

11 “(B) LIMITATION ON INCREASE.—In the
12 case of a taxpayer whose household income is
13 less than 400 percent of the poverty line for the
14 size of the family involved for the taxable year,
15 the amount of the increase under subparagraph
16 (A) shall in no event exceed the applicable dol-
17 lar amount determined in accordance with the
18 following table (one-half of such amount in the
19 case of a taxpayer whose tax is determined
20 under section 1(c) for the taxable year):

“If the household income (expressed as a percent of poverty line) is:	The applicable dollar amount is:
Less than 200%	\$600
At least 200% but less than 300%	\$1,500
At least 300% but less than 400%	\$2,500.

21 “(e) SPECIAL RULES.—For purpose of this section—

1 “(1) ADVANCE PAYMENT PROGRAM.—

2 “(A) IN GENERAL.—The Secretary of the
3 Treasury, in consultation with the Secretary of
4 Health and Human Services, shall establish a
5 program—

6 “(i) to make advance determinations
7 with respect to the eligibility of individuals
8 for the credit allowed under this section,
9 and

10 “(ii) to make advance payments of the
11 credit allowed under this section, at the
12 election of any such individual so eligible,
13 directly to the health savings account of
14 any such individual, or, as a subsidy to the
15 cost of health insurance coverage provided
16 to any such individual, to the health insur-
17 ance issuer providing such coverage or the
18 person that administers the plan benefits
19 with respect to such coverage.

20 “(B) PROGRAM REQUIREMENTS.—Such
21 program shall be established under rules similar
22 to the rules of section 1412 of the Patient Pro-
23 tection and Affordable Care Act, as in effect on
24 the day before the date of the enactment of this
25 section, except that advance determinations and

1 advance payments shall be made on request of
2 the individual with respect to whom the deter-
3 mination is to be made.

4 “(2) INFORMATION REQUIREMENTS.—

5 “(A) IN GENERAL.—Each person providing
6 health insurance coverage which constitutes
7 medical care, and each trustee of a health sav-
8 ings account, shall provide the following infor-
9 mation to the Secretary and to the taxpayer
10 with respect to such coverage or such account:

11 “(i) The total premium for the cov-
12 erage without regard to the credit under
13 this section.

14 “(ii) The aggregate amount of any ad-
15 vance payment of such credit made with
16 respect to such coverage or to such ac-
17 count.

18 “(iii) The name, address, age, and
19 TIN of the primary insured or account
20 holder (as the case may be) and the name,
21 age, and TIN of each other individual ob-
22 taining coverage under such policy of in-
23 surance.

1 “(iv) Any information provided to
2 such person necessary to determine eligi-
3 bility for, and the amount of, such credit.

4 “(v) Information necessary to deter-
5 mine whether a taxpayer has received ex-
6 cess advance payments.

7 “(B) EXCEPTION.—Subparagraph (A)
8 shall not apply to any coverage with respect to
9 which reporting under section 6051 is required.

10 “(3) INDEXING.—

11 “(A) IN GENERAL.—In the case of any cal-
12 endar year beginning after 2016, each of the
13 dollar amounts in subsection (b)(2) and in the
14 table contained under subsection (d)(2)(B) shall
15 be equal to such dollar amount multiplied by
16 the ratio of—

17 “(i) the current dollar gross domestic
18 product (as determined based on the third
19 estimate of the Bureau of Economic Anal-
20 ysis of the Department of Commerce for
21 the second quarter of the previous year), to

22 “(ii) the current dollar gross domestic
23 product (as so determined) for the second
24 quarter of 2015.

1 “(B) ROUNDING.—If the amount of any
 2 change under subparagraph (A) is not a mul-
 3 tiple of \$50, such change shall be rounded to
 4 the next lowest multiple of \$50.

5 “(f) DEFINITIONS.—For purposes of this section—

6 “(1) CREDITABLE COVERAGE.—

7 “(A) IN GENERAL.—The term ‘creditable
 8 coverage’ has the meaning given such term for
 9 purposes of title XXVII of the Public Health
 10 Service Act. Such term shall not include cov-
 11 erage under any health plan that includes cov-
 12 erage for abortions (other than any abortion de-
 13 scribed in subparagraph (B)).

14 “(B) EXCEPTION.—The second sentence of
 15 subparagraph (A) shall not apply to an abor-
 16 tion—

17 “(i) if the pregnancy is the result of
 18 an act of rape or incest, or

19 “(ii) in the case where a woman suf-
 20 fers from a physical disorder, physical in-
 21 jury, or physical illness that would, as cer-
 22 tified by a physician, place the woman in
 23 danger of death unless an abortion is per-
 24 formed, including a life-endangering phys-

1 ical condition caused by or arising from
2 the pregnancy itself.

3 “(C) SEPARATE ABORTION COVERAGE OR
4 PLAN ALLOWED.—

5 “(i) OPTION TO PURCHASE SEPARATE
6 COVERAGE OR PLAN.—Nothing in subpara-
7 graph (A) shall be construed as prohibiting
8 any individual from purchasing separate
9 coverage for abortions described in such
10 subparagraph, or a health plan that in-
11 cludes such abortions, so long as no credit
12 is allowed under this section with respect
13 to the premiums for such coverage or plan.

14 “(ii) OPTION TO OFFER COVERAGE OR
15 PLAN.—Nothing in subparagraph (A) shall
16 restrict any non-Federal health insurance
17 issuer offering a health plan from offering
18 separate coverage for abortions described
19 in such subparagraph, or a plan that in-
20 cludes such abortions, so long as premiums
21 for such separate coverage or plan are not
22 paid for with any amount attributable to
23 the credit allowed under this section (or
24 the amount of any advance payment of the
25 credit).

1 “(2) QUALIFIED RESIDENT.—The term ‘quali-
2 fied resident’ means an individual who is a citizen or
3 national of the United States or otherwise lawfully
4 residing in the United States under color of law.”.

5 (b) DISQUALIFICATION FROM EXCHANGE PLAN SUB-
6 SIDIES FOR INDIVIDUAL ONCE THEY ELECT TAX BENE-
7 FITS.—Section 36B(c)(1) of such Code is amended by
8 adding at the end the following new subparagraph:

9 “(E) DENIAL OF CREDIT FOR THOSE
10 ELECTING UNIVERSAL CREDIT.—In the case of
11 an individual who is allowed a credit under sec-
12 tion 36C for any taxable year, no credit shall be
13 allowed under this section to such individual for
14 such taxable year or any subsequent taxable
15 year.”.

16 (c) GUIDANCE.—The Secretary of the Treasury shall
17 issue such guidance as is necessary—

18 (1) to assist employees and employers in adjust-
19 ing Federal income tax withholding to take into ac-
20 count the health insurance tax credit under section
21 36C of the Internal Revenue Code of 1986 (and any
22 advance payment thereof), and

23 (2) to require employers to report to each em-
24 ployee with respect to periods not longer than quar-
25 terly the employer-provided health insurance tax

1 subsidy (as defined in section 36C(c)(2) of such
2 Code) with respect to such employee for such period.

3 (d) CLERICAL AMENDMENT.—The table of sections
4 for subpart C of part IV of subchapter A of chapter 1
5 of the Internal Revenue Code of 1986 is amended by in-
6 serting after the item relating to section 36B the following
7 new item:

“Sec. 36C. Health insurance tax credit.”.

8 (e) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to taxable years beginning after
10 December 31, 2015.

11 **SEC. 132. APPLICATION OF PORTION OF UNUSED TAX**
12 **CREDITS BY STATES FOR INDIGENT HEALTH**
13 **CARE.**

14 (a) COMPUTATION OF UNUSED CREDITS.—The Sec-
15 retary, in consultation with the Secretary of the Treasury,
16 shall calculate for each State for each year, beginning with
17 2017, using the most recent data available —

18 (1) the maximum aggregate amount of credits
19 under section 36C of the Internal Revenue Code of
20 1986 that would have been allowed for the year for
21 qualified residents of the State for taxable years
22 ending in the year if all eligible qualified residents
23 had qualified for such credits;

24 (2) the aggregate amount of credits under such
25 section that were allowed for taxable years ending in

1 that the year by qualified residents of such State;
2 and

3 (3) 25 percent of the amount by which—

4 (A) the amount determined under para-
5 graph (1) with respect to qualified residents of
6 the State for such year; exceeds

7 (B) the amount determined under para-
8 graph (2) for such State for that year.

9 (b) APPROPRIATION.—For the purpose of making
10 grants to States under this section, there is hereby appro-
11 priated to the Secretary, out of any funds in the Treasury
12 not otherwise appropriated, for each year (beginning with
13 2017) an amount equivalent to the amount determined
14 under subsection (a)(3) for all States under subsection (a)
15 for the year in which such fiscal year ends, subject to ad-
16 justment under subsection (d)(2).

17 (c) GRANTS TO STATES FOR INDIGENT ASSIST-
18 ANCE.—

19 (1) APPLICATION.—A State may file with the
20 Secretary (in a form and manner specified by the
21 Secretary) an application to provide assistance in
22 furnishing health services to indigent individuals re-
23 siding in the State. Such application shall dem-
24 onstrate the manner in which such assistance is fur-

1 nished in an equitable manner to individuals residing
2 in all parts of the State.

3 (2) AMOUNT OF FUNDS.—From the funds ap-
4 propriated under subsection (b) for a year, the
5 amount of funds paid to any State in any year
6 under this section with an application filed in ac-
7 cordance with paragraph (1) is equal to an amount
8 specified in the application, but not to exceed the
9 amount computed under subsection (a)(3) for the
10 State and the year.

11 (3) USE OF FUNDS.—Funds paid to a State
12 under this subsection may be used only to assist in
13 the furnishing of health services to uninsured indi-
14 viduals residing in the State or for purposes of in-
15 creasing the payment adjustments made under sec-
16 tions 1886(d)(5)(F) and 1923 of the Social Security
17 Act (42 U.S.C. 1395ww(d)(5)(F), 1396r-4) to hos-
18 pitals that serve a disproportionate share of such in-
19 dividuals in the State.

20 (d) INITIAL ESTIMATE; FINAL CALCULATION AND
21 RECONCILIATION.—

22 (1) USE OF ESTIMATES.—The calculations
23 under subsection (a) for a year shall initially be esti-
24 mated before the beginning of the year. Payments
25 under this section to a State for a year shall be

1 made, subject to reconciliation under paragraph (2),
 2 based on the amount so estimated.

3 (2) RECONCILIATION BASED ON FINAL CAL-
 4 CULATION.—The calculations under subsection (a)
 5 for a year shall also be made after the end of the
 6 year. Insofar as the amount calculated under this
 7 paragraph for subsection (a)(3) for a State for a
 8 year exceeds (or is less than) by a material amount
 9 from the amount for subsection (a)(3) estimated and
 10 applied for the State and year under paragraph (1),
 11 the amount calculated under subsection (a)(3) for
 12 the State for the 2nd year beginning after such year,
 13 shall be reduced or increased, respectively by the
 14 amount of such excess or deficit.

15 **SEC. 133. MEDICAID OPTION OF ENROLLMENT UNDER PRI-**
 16 **VATE PLAN AND CONTRIBUTION TO AN HSA.**

17 (a) IN GENERAL.—Notwithstanding any other provi-
 18 sion of law, a State plan under title XIX of the Social
 19 Security Act (42 U.S.C. 1396 et seq.) may make available
 20 to an individual, who is entitled to medical assistance for
 21 a full range of acute care items and services under such
 22 title and at the individual's option, instead of the medical
 23 assistance otherwise provided, medical assistance con-
 24 sisting of coverage under a health plan that qualifies for
 25 a tax credit under section 36C of the Internal Revenue

1 Code of 1986, but only if the State provides for the indi-
 2 vidual medical assistance, in the form of a deposit into
 3 a health savings account for the individual, an amount
 4 equivalent to the amount by which the amount of tax cred-
 5 it for the individual under such section exceeds the cost
 6 of coverage of the individual under the plan.

7 (b) FFP TREATMENT.—The payments by a State de-
 8 scribed in subsection (a) for coverage under a health plan
 9 and for deposit into a health savings account shall be
 10 treated as medical assistance for purposes of section 1903
 11 of the Social Security Act (42 U.S.C. 1396b) and subject
 12 to Federal financial participating, including the applica-
 13 tion of State matching payments, in the same manner as
 14 other medical assistance furnished under title XIX of such
 15 Act, except that such amount shall be reduced by the
 16 amount of any health insurance credits provided under
 17 section 36C of the Internal Revenue Code of 1986 with
 18 respect to such coverage or deposit.

19 **SEC. 134. REPEAL OF THE TAX ON EMPLOYEE HEALTH IN-**
 20 **SURANCE PREMIUMS AND HEALTH PLAN**
 21 **BENEFITS AND RELATED REPORTING RE-**
 22 **QUIREMENTS.**

23 (a) EXCISE TAX.—Chapter 43 of the Internal Rev-
 24 enue Code of 1986 is amended by striking section 4980I.

1 (b) REPORTING REQUIREMENT.—Section 6051(a) of
 2 such Code is amended by inserting “and” at the end of
 3 paragraph (12), by striking “, and” at the end of para-
 4 graph (13) and inserting a period, and by striking para-
 5 graph (14).

6 (c) CLERICAL AMENDMENT.—The table of sections
 7 for chapter 43 of such Code is amended by striking the
 8 item relating to section 4980I.

9 (d) EFFECTIVE DATES.—

10 (1) IN GENERAL.—Except as provided by para-
 11 graph (2), the amendments made by this section
 12 shall apply to taxable years beginning after Decem-
 13 ber 31, 2019.

14 (2) REPORTING REQUIREMENT.—The amend-
 15 ment made by subsection (b) shall apply to calendar
 16 years beginning after December 31, 2016.

17 **TITLE II—IMPROVING HEALTH** 18 **SAVINGS ACCOUNTS TO PRO-** 19 **MOTE ACCOUNTABILITY**

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

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

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

“Sec. 530A. Roth HSAs.

1 **“SEC. 530A. ROTH HSAS.**

2 “(a) IN GENERAL.—A Roth HSA shall be exempt
3 from taxation under this subtitle. Notwithstanding the
4 preceding sentence, the Roth HSA shall be subject to the
5 taxes imposed by section 511 (relating to imposition of
6 tax on unrelated business income of charitable organiza-
7 tions). No deduction shall be allowed for any contribution
8 to a Roth HSA.

9 “(b) DOLLAR LIMITATION.—

10 “(1) IN GENERAL.—The aggregate amount of
11 contributions for any taxable year to all Roth HSAs
12 maintained for the benefit of an individual shall not
13 exceed the sum of the monthly limitations for month
14 during such taxable year that the individual is an el-
15 igible individual.

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

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

21 “(B) in the case of an eligible individual
22 who has family creditable coverage as of the
23 first day of such month, the amount in effect
24 under subparagraph (A) for the taxable year
25 multiplied by the number of individuals (includ-

1 ing the eligible individual) covered under such
2 family creditable coverage as of such day.

3 “(3) ADDITIONAL CONTRIBUTIONS FOR INDIVIDUALS 55 OR OLDER.—In the case of an individual
4 who has attained age 55 before the close of the taxable
5 year, the applicable limitation under subparagraphs (A) and (B) of paragraph (2) shall be increased by \$1,000.
6

7 “(4) COORDINATION WITH OTHER CONTRIBUTIONS.—The limitation which would (but for this
8 paragraph) apply under this subsection to an individual for any taxable year shall be reduced (but not
9 below zero) by the sum of—
10

11 “(A) the aggregate amount paid for such
12 taxable year to Archer MSAs of such individual,
13

14 “(B) the aggregate amount contributed to
15 Roth HSAs of such individual which is excludable from the taxpayer’s gross income for such
16 taxable year under section 106(d) (and such amount shall not be allowed as a deduction
17 under subsection (a)), and
18

19 “(C) the aggregate amount contributed to
20 Roth HSAs of such individual for such taxable
21 year under section 408(d)(9) (and such amount
22

1 shall not be allowed as a deduction under sub-
2 section (a)).

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

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

8 “(A) both spouses shall be treated as hav-
9 ing only such family coverage (and if such
10 spouses each have family coverage under dif-
11 ferent plans, as having the family coverage with
12 the lowest annual deductible), and

13 “(B) the limitation under paragraph (1)
14 (after the application of subparagraph (A) and
15 without regard to any additional contribution
16 amount under paragraph (3))—

17 “(i) shall be reduced by the aggregate
18 amount paid to Archer MSAs of such
19 spouses for the taxable year, and

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

23 “(6) DENIAL OF DEDUCTION TO DEPEND-
24 ENTS.—No contribution may be made to a Roth
25 HSA under this section by any individual with re-

1 spect to whom a deduction under section 151 is al-
2 lowable to another taxpayer for a taxable year begin-
3 ning in the calendar year in which such individual's
4 taxable year begins.

5 “(7) MEDICARE ELIGIBLE INDIVIDUALS.—The
6 limitation under this subsection for any month with
7 respect to an individual shall be zero for the first
8 month such individual is entitled to benefits under
9 title XVIII of the Social Security Act and for each
10 month thereafter.

11 “(8) INCREASE IN LIMIT FOR INDIVIDUALS BE-
12 COMING ELIGIBLE INDIVIDUALS AFTER THE BEGIN-
13 NING OF THE YEAR.—

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

19 “(i) as having been an eligible indi-
20 vidual during each of the months in such
21 taxable year, and

22 “(ii) as having been enrolled, during
23 each of the months such individual is
24 treated as an eligible individual solely by
25 reason of clause (i), in the same high de-

ductible health plan in which the individual was enrolled for the last month of such taxable year.

“(B) FAILURE TO MAINTAIN CREDITABLE COVERAGE.—

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

“(I) gross income of the individual for the taxable year in which occurs the first month in the testing period for which such individual is not an eligible individual is increased by the aggregate amount of all contributions to the Roth HSA of the individual which could not have been made but for subparagraph (A), and

“(II) the tax imposed by this chapter for any taxable year on the individual shall be increased by 10 percent of the amount of such increase.

“(ii) EXCEPTION FOR DISABILITY OR DEATH.—Subclauses (I) and (II) of clause (i) shall not apply if the individual ceased

1 to be an eligible individual by reason of the
2 death of the individual or the individual
3 becoming disabled (within the meaning of
4 section 72(m)(7)).

5 “(iii) TESTING PERIOD.—The term
6 ‘testing period’ means the period beginning
7 with the last month of the taxable year re-
8 ferred to in subparagraph (A) and ending
9 on the last day of the 12th month fol-
10 lowing such month.

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

12 “(1) IN GENERAL.—The term ‘Roth HSA’
13 means a trust created or organized in the United
14 States as a Roth HSA exclusively for the purpose of
15 paying the qualified medical expenses of the account
16 beneficiary, but only if the written governing instru-
17 ment creating the trust meets the following require-
18 ments:

19 “(A) Except in the case of a rollover con-
20 tribution described in subsection (f)(5) or sec-
21 tion 220(f)(5), no contribution will be accept-
22 ed—

23 “(i) unless it is in cash, or

24 “(ii) to the extent such contribution,
25 when added to previous contributions to

1 the trust for the calendar year, exceeds the
2 sum of—

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

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

7 “(B) The trustee is a bank (as defined in
8 section 408(n)), an insurance company (as de-
9 fined in section 816), or another person who
10 demonstrates to the satisfaction of the Sec-
11 retary that the manner in which such person
12 will administer the trust will be consistent with
13 the requirements of this section.

14 “(C) No part of the trust assets will be in-
15 vested in life insurance contracts.

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

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

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

24 “(A) IN GENERAL.—The term ‘qualified
25 medical expenses’ means, with respect to an ac-

count 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 World's Greatest Healthcare Plan of 2017) for such individual, the spouse of such individual, and any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

“(B) LIMITATION ON HEALTH INSURANCE PURCHASED FROM ACCOUNT.—Such term shall not include any payment for health benefits coverage that is not creditable coverage (as defined in section 36C).

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

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

“(ii) a qualified long-term care insurance contract (as defined in section 7702B(b)),

1 “(iii) a health plan during a period in
 2 which the individual is receiving unemploy-
 3 ment compensation under any Federal or
 4 State law, or

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

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

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

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

19 “(B) Except as provided in section 106(d),
 20 section 219(f)(5) (relating to employer pay-
 21 ments).

22 “(C) Section 408(g) (relating to commu-
 23 nity property laws).

24 “(D) Section 408(h) (relating to custodial
 25 accounts).

1 “(d) ELIGIBLE INDIVIDUAL; CREDITABLE COV-
2 ERAGE.—For purposes of this section—

3 “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible
4 individual’ means, with respect to any month, any
5 individual if such individual is covered under cred-
6 itable coverage as of the first day of such month.

7 “(2) CREDITABLE COVERAGE.—The term ‘cred-
8 itable coverage’ shall have the meaning given such
9 term in section 36C(f).

10 “(e) TAX TREATMENT OF DISTRIBUTIONS.—

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

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

1 any Roth HSA of an individual, paragraph (2)
2 shall not apply to distributions from the Roth
3 HSAs of such individual (to the extent such dis-
4 tributions do not exceed the aggregate excess
5 contributions to all such accounts of such indi-
6 vidual for such year) if—

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

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

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

18 “(B) EXCESS CONTRIBUTION.—For pur-
19 poses of subparagraph (A), the term ‘excess
20 contribution’ means any contribution (other
21 than a rollover contribution described in para-
22 graph (5) or section 220(f)(5)) which exceeds
23 the contribution limitation with respect to the
24 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 2016, 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 2015’ 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 December
8 31, 2016.

9 “(2) EXCEPTIONS.—Paragraph (1) shall not
10 apply—

11 “(A) in the case of a rollover contribution
12 described in subsection (f)(5) or section
13 220(f)(5), or

14 “(B) in the case of a month for which an
15 individual is covered by insurance that con-
16 stitutes medical care and that is provided by an
17 employer with respect to which an election is in
18 effect for such month under section 131(b) of
19 the World’s Greatest Healthcare Plan of
20 2017.”.

21 (c) CLERICAL AMENDMENT.—The table of parts for
22 subchapter F of chapter 1 of such Code is amended by
23 adding at the end the following new item:

“PART IX. ROTH HEALTH SAVINGS ACCOUNTS”.

1 (d) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to taxable years beginning after
 3 December 31, 2016.

4 **SEC. 202. ELIMINATION OF MEDICAL EXPENSE DEDUCTION.**

5 Section 213 of the Internal Revenue Code of 1986
 6 is amended by adding at the end the following new sub-
 7 section:

8 “(g) TERMINATION.—Except in the case of long-term
 9 care premiums (as defined in subsection (d)(10)), sub-
 10 section (a) shall not apply to any amounts paid during
 11 any taxable year beginning after December 31, 2015.”.

12 **SEC. 203. TREATMENT OF HSA AFTER DEATH OF ACCOUNT**
 13 **BENEFICIARY.**

14 (a) IN GENERAL.—Section 223(f)(8) of the Internal
 15 Revenue Code of 1986 is amended to read as follows:

16 “(8) TREATMENT AFTER DEATH OF ACCOUNT
 17 BENEFICIARY.—If an individual acquires an account
 18 beneficiary’s interest in a health savings account by
 19 reason of the death of the account beneficiary, such
 20 health savings account shall be treated as if the indi-
 21 vidual were the account beneficiary.”.

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

1 **SEC. 204. TREATMENT OF CONCIERGE MEDICINE.**

2 (a) HSAs.—

3 (1) ROTH HSA.—Section 530A(c)(2)(A) of the
4 Internal Revenue Code of 1986, as added by section
5 201(a) of this Act, is amended by adding at the end
6 the following: “Such term shall include the payment
7 of a monthly or other prepaid amount for the fur-
8 nishing (or access to the furnishing) by a physician
9 or group of physicians of physician professional serv-
10 ices (and ancillary services).”.

11 (2) HSA.—Section 223(d)(2)(A) of such Code
12 is amended by adding at the end the following:
13 “Such term shall include the payment of a monthly
14 or other prepaid amount for the furnishing (or ac-
15 cess to the furnishing) by a physician or group of
16 physicians of physician professional services (and an-
17 cillary services).”.

18 (b) NOT TREATED AS HEALTH INSURANCE COV-
19 ERAGE.—

20 (1) IN GENERAL.—For purposes of title XXVII
21 of the Public Health Service Act (42 U.S.C. 300gg),
22 subtitle B of title I of the Employee Retirement and
23 Income Security Act of 1974 (29 U.S.C. 1021 et
24 seq.), PPACA, and this Act, the offering of con-
25 cierge medicine shall not be treated as the offering

1 of health insurance coverage and shall not be subject
 2 to regulations as such coverage under such Acts.

3 (2) CONCIERGE MEDICINE DEFINED.—In this
 4 subsection, the term “concierge medicine” means the
 5 furnishing (or access to the furnishing) by a physi-
 6 cian or group of physicians of physician professional
 7 services (and ancillary services) in return for pay-
 8 ment of a monthly or other prepaid amount.

9 **TITLE III—STATE FLEXIBILITY**
 10 **IN REGULATION OF HEALTH**
 11 **INSURANCE COVERAGE**

12 **SEC. 301. STATE FLEXIBILITY IN REGULATION OF HEALTH**
 13 **INSURANCE COVERAGE.**

14 (a) IN GENERAL.—States are given the flexibility
 15 under section 122(b) to revise their regulations of the
 16 health insurance marketplace, without regard to many of
 17 the requirements imposed under PPACA, in order to pro-
 18 mote freedom of choice of affordable health insurance cov-
 19 erage options offered outside of an Exchange.

20 (b) CONSTRUCTION.—Nothing in the Employee Re-
 21 tirement and Income Security Act of 1974 (29 U.S.C.
 22 1001 et seq.) or of any amendments made by the Health
 23 Insurance Portability and Accountability Act of 1996
 24 (Public Law 104–191) shall be interpreted as preventing
 25 an employer from offering, or making an employer con-

1 tribution towards, individual health insurance coverage for
2 employees and dependent family members.

3 (c) ASSOCIATION HEALTH PLANS.—Nothing in this
4 Act shall be construed as prohibiting the formation of as-
5 sociation health plans (as defined under State law).

6 (d) HIGH-RISK POOLS.—Nothing in this Act shall be
7 construed as prohibiting States from establishing pooling
8 arrangements for high-risk individuals.

9 **TITLE IV—MEDICAID PAYMENT** 10 **REFORM**

11 **SEC. 401. MEDICAID PAYMENT REFORM.**

12 (a) IN GENERAL.—Title XIX of the Social Security
13 Act (42 U.S.C. 1396 et seq.) is amended by inserting after
14 section 1903 the following section:

15 **“SEC. 1903A. REFORMED PAYMENT TO STATES.**

16 “(a) REFORMED PAYMENT SYSTEM.—

17 “(1) IN GENERAL.—For quarters beginning on
18 or after the implementation date (as defined in sub-
19 section (k)(1)), in lieu of amounts otherwise payable
20 to a State under this title (including any payments
21 attributable to section 1923), except as otherwise
22 provided in this section, the amount payable to such
23 State shall be equal to the sum of the following:

24 “(A) ADJUSTED AGGREGATE BENE-
25 FICIARY-BASED AMOUNT.—The aggregate bene-

1 ficiary-based amount specified in subsection (b)
 2 for the quarter and the State, adjusted under
 3 subsection (e).

4 “(B) CHRONIC CARE QUALITY BONUS.—

5 The amount (if any) of the chronic care quality
 6 bonus payment specified in subsection (f) for
 7 the quarter for the State.

8 “(2) REQUIREMENT OF STATE SHARE.—

9 “(A) IN GENERAL.—A State shall make,
 10 from non-Federal funds, expenditures in an
 11 amount equal to its State share (as determined
 12 under subparagraph (B)) for a quarter for
 13 items, services, and other costs for which, but
 14 for paragraph (1), Federal funds would have
 15 been payable under this title.

16 “(B) STATE SHARE.—The State share for
 17 a State for a quarter in a fiscal year is equal
 18 to the product of—

19 “(i) the aggregate beneficiary-based
 20 amount specified in subsection (b) for the
 21 quarter and the State; and

22 “(ii) the ratio of—

23 “(I) the State percentage de-
 24 scribed in subparagraph (D)(ii) for
 25 such State and fiscal year; to

1 “(II) the Federal percentage de-
2 scribed in subparagraph (D)(i) for
3 such State and fiscal year.

4 “(C) NONPAYMENT FOR FAILURE TO PAY
5 STATE SHARE.—

6 “(i) IN GENERAL.—If a State fails to
7 expend the amount required under sub-
8 paragraph (A) for a quarter in a fiscal
9 year, the amount payable to the State
10 under paragraph (1) shall be reduced by
11 the product of the amount by which the
12 State payment is less than the State share
13 and the ratio of—

14 “(I) the Federal percentage de-
15 scribed in subparagraph (D)(i) for
16 such State and fiscal year; to

17 “(II) the State percentage de-
18 scribed in subparagraph (D)(ii) for
19 such State and fiscal year.

20 “(ii) GRACE PERIOD.—A State shall
21 not be considered to have failed to provide
22 payment of its required State share for a
23 quarter under subparagraph (A) if the ag-
24 gregate State payment towards the State’s
25 required State share for the 4-quarter pe-

1 riod beginning with such quarter exceeds
2 the required State share amount for such
3 4-quarter period.

4 “(D) FEDERAL AND STATE PERCENT-
5 AGES.—In this paragraph, with respect to a
6 State and a fiscal year:

7 “(i) FEDERAL PERCENTAGE.—The
8 Federal percentage described in this clause
9 is 75 percent or, if higher, the Federal
10 medical assistance percentage for such
11 State for such fiscal year.

12 “(ii) STATE PERCENTAGE.—The State
13 percentage described in this clause is 100
14 percent minus the Federal percentage de-
15 scribed in clause (i).

16 “(E) RULES FOR CREDITING TOWARD
17 STATE SHARE.—

18 “(i) GENERAL LIMITATION TO MATCH-
19 ABLE EXPENDITURES.—A payment for ex-
20 penditures shall not be counted toward the
21 State share under subparagraph (A) unless
22 Federal payments may be used for such
23 expenditures consistent with paragraph
24 (3)(B).

1 “(ii) FURTHER LIMITATIONS ON AL-
2 LOWABLE EXPENDITURES.—A payment for
3 expenditures shall not be counted towards
4 the State share under subparagraph (A) if
5 the expenditure is for any of the following:

6 “(I) ABORTION.—Expenditures
7 for an abortion.

8 “(II) INTERGOVERNMENTAL
9 TRANSFERS.—An expenditure that is
10 attributable to an intergovernmental
11 transfer.

12 “(III) CERTIFIED PUBLIC EX-
13 PENDITURES.—An expenditure that is
14 attributable to certified public expend-
15 itures.

16 “(iii) CREDITING FRAUD AND ABUSE
17 RECOVERIES.—Amounts recovered by a
18 State through the operation of its Medicaid
19 fraud and abuse control unit described in
20 section 1903(q) shall be fully counted to-
21 ward the State share under subparagraph
22 (A).

23 “(F) CONSTRUCTION.—Nothing in the
24 paragraph shall be construed as preventing a
25 State from expending, from non-Federal funds,

1 an amount under this title in excess of the
2 amount of the State share.

3 “(G) DETERMINATION BASED UPON SUB-
4 MITTED CLAIMS.—In applying this paragraph
5 with respect to expenditures of a State for a
6 quarter, the determination of the expenditures
7 for such State for such quarter shall be made
8 after the end of the period (which, as of the
9 date of the enactment of this section, is 2
10 years) for which the Secretary accepts claims
11 for payment under this title with respect to
12 such quarter.

13 “(3) USE OF FEDERAL PAYMENTS.—

14 “(A) APPLICATION OF MEDICAID LIMITA-
15 TIONS.—A State may only use Federal pay-
16 ments received under subsection (a) for expend-
17 itures for which Federal funds would have been
18 payable under this title but for this section.

19 “(B) LIMITATION FOR CERTAIN ELIGI-
20 BLES.—

21 “(i) APPLICATION OF 100 PERCENT
22 FEDERAL POVERTY LINE LIMIT ON ELIGI-
23 BILITY.—Subject to clause (iii), a State
24 may not use such Federal payments to
25 provide medical assistance for an indi-

vidual who has an income (as determined under clause (ii)) that exceeds 100 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved.

“(ii) DETERMINATION OF INCOME USING MODIFIED ADJUSTED GROSS INCOME WITHOUT ANY 5 PERCENT INCREASE.—In determining income for purposes of clause (i) under section 1902(e)(14) (relating to modified adjusted gross income), the following rules shall apply:

“(I) APPLICATION OF SPEND DOWN.—The State shall take into account the costs incurred for medical care or for any other type of remedial care recognized under State law in the same manner and to the same extent that such State takes such costs into account for purposes of section 1902(a)(17).

“(II) DISREGARD OF 5 PERCENT INCREASE.—Subparagraph (I) of sec-

1 tion 1902(e)(14) (relating to a 5 per-
2 cent reduction) shall not apply.

3 “(iii) EXCEPTION.—Clause (i) shall
4 not apply to an individual who is—

5 “(I) a woman described in clause
6 (i) of section 1903(v)(4)(A);

7 “(II) a child who is an individual
8 described in clause (i) of section
9 1905(a);

10 “(III) enrolled in a State plan
11 under this title as of the date of the
12 enactment of this section for the pe-
13 riod of continuous enrollment; or

14 “(IV) described in section
15 1902(e)(14)(D) (relating to modified
16 adjusted gross income).

17 “(iv) CLARIFICATION RELATED TO
18 COMMUNITY SPOUSE.—Nothing in this
19 subparagraph shall supersede the applica-
20 tion of section 1924 (related to community
21 spouse income and assets).

22 “(4) EXCEPTIONS FOR PASS-THROUGH PAY-
23 MENTS.—

24 “(A) IN GENERAL.—Paragraph (1) shall
25 not apply, and amounts shall continue to be

1 payable under this title (and not under sub-
2 section (a)), in the case of the following pay-
3 ments (and related administrative costs and ex-
4 penditures):

5 “(i) PAYMENTS TO TERRITORIES.—

6 Payments to a State other than the 50
7 States and the District of Columbia.

8 “(ii) MEDICARE COST SHARING.—

9 Payments attributable to Medicare cost
10 sharing under section 1905(p).

11 “(iii) PEDIATRIC VACCINES.—Pay-

12 ments attributable to section 1928.

13 “(iv) EMERGENCY SERVICES FOR CER-

14 TAIN INDIVIDUALS.—Payments for treat-
15 ment of emergency medical conditions at-
16 tributable to the application of section
17 1903(v)(2).

18 “(v) INDIAN HEALTH CARE FACILI-

19 TIES.—Payments for medical assistance
20 described in the third sentence of section
21 1905(b).

22 “(vi) EMPLOYER-SPONSORED INSUR-

23 ANCE (ESI).—Payments for medical assist-
24 ance attributable to payments to employers

1 for employer-sponsored health benefits cov-
2 erage.

3 “(vii) OTHER POPULATIONS WITH
4 LIMITED BENEFIT COVERAGE.—Other pay-
5 ments that are determined by the Sec-
6 retary to be related to a specified popu-
7 lation for which the medical assistance
8 under this title is limited and does not in-
9 clude any inpatient, nursing facility, or
10 long-term care services.

11 “(B) CERTAIN EXPENSES.—Paragraph (1)
12 shall not apply, and amounts shall continue to
13 be payable under this title (and not under sub-
14 section (a)), in the case of the following:

15 “(i) ADMINISTRATION OF MEDICARE
16 PRESCRIPTION DRUG BENEFIT.—Expendi-
17 tures described in section 1935(b) (relating
18 to administration of the Medicare prescrip-
19 tion drug benefit).

20 “(ii) PAYMENTS FOR HIT BONUSES.—
21 Payments under section 1903(a)(3)(F) (re-
22 lating to payments to encourage the adop-
23 tion and use of certified EHR technology).

24 “(iii) PAYMENTS FOR DESIGN, DEVEL-
25 OPMENT, AND INSTALLATION OF MMIS AND

1 ELIGIBILITY SYSTEMS.—Payments under
2 subparagraphs (A)(i) and (H)(i) of section
3 1903(a)(3) for expenditures for design, de-
4 velopment, and installation of the Medicaid
5 management information systems and
6 mechanized verification and information
7 retrieval systems (related to eligibility).

8 “(5) PAYMENT OF AMOUNTS.—

9 “(A) IN GENERAL.—Except as the Sec-
10 retary may otherwise provide, amounts shall be
11 payable to a State under subsection (a) in the
12 same manner as amounts are payable under
13 subsection (d) of section 1903 to a State under
14 subsection (a) of such section.

15 “(B) INFORMATION AND FORMS.—

16 “(i) SUBMISSION.—As a condition of
17 receiving payment under subsection (a), a
18 State shall submit such information, in
19 such form, and manner, as the Secretary
20 shall specify, including information nec-
21 essary to make the computations under
22 subsections (c)(2)(C) and (e).

23 “(ii) UNIFORM REPORTING.—The
24 Secretary shall develop such forms as may
25 be needed to assure a system of uniform

1 reporting of such information across
2 States.

3 “(C) REQUIRED REPORTING OF INFORMA-
4 TION ON MEDICAL LOSS RATIOS FOR MANAGED
5 CARE.—The information required to be reported
6 under subparagraph (B)(i) shall include infor-
7 mation on the medical loss ratio with respect to
8 coverage provided under each Medicaid man-
9 aged care plan with a contract with the State
10 under section 1903(m) or 1932.

11 “(b) AGGREGATE BENEFICIARY-BASED AMOUNT.—

12 “(1) IN GENERAL.—The aggregate beneficiary-
13 based amount specified in this subsection for a State
14 for a quarter is equal to the sum of the products,
15 for each of the categories of Medicaid beneficiaries
16 specified in paragraph (2), of the following:

17 “(A) BENEFICIARY-BASED QUARTERLY
18 AMOUNT.—The beneficiary-based quarterly
19 amount for such category computed under sub-
20 section (c) for such State for such quarter.

21 “(B) NUMBER OF INDIVIDUALS IN CAT-
22 EGORY.—Subject to subsection (d), the average
23 number of Medicaid beneficiaries enrolled in
24 such category in the State in such quarter.

1 “(2) CATEGORIES.—The categories specified in
2 this paragraph are the following:

3 “(A) ELDERLY.—A category of Medicaid
4 beneficiaries who are 65 years of age or older.

5 “(B) BLIND OR DISABLED.—A category of
6 Medicaid beneficiaries not described in subpara-
7 graph (A) who are described in section
8 1937(a)(2)(B)(ii).

9 “(C) CHILDREN.—A category of Medicaid
10 beneficiaries not described in subparagraph (B)
11 who are under 21 years of age.

12 “(D) OTHER ADULTS.—A category of any
13 Medicaid beneficiaries who are not described in
14 a previous subparagraph of this paragraph.

15 “(c) COMPUTATION OF PER BENEFICIARY, PER CAT-
16 EGORY QUARTERLY AMOUNT.—

17 “(1) IN GENERAL.—For a State, for each cat-
18 egory of beneficiary for a quarter—

19 “(A) FIRST REFORM YEAR.—For quarters
20 in the first reform year (as defined in sub-
21 section (k)(2)), the beneficiary-based quarterly
22 amount is equal to $\frac{1}{4}$ of the base average per
23 beneficiary Federal payments for such State for
24 such category determined under paragraph (2),

1 increased by a factor that reflects the sum of
2 the following:

3 “(i) HISTORICAL MEDICAL CARE COM-
4 PONENT OF CPI THROUGH PREVIOUS RE-
5 FORM YEAR.—The percentage increase in
6 the historical medical care component of
7 the Consumer Price Index for all urban
8 consumers (U.S. city average) from the
9 midpoint of the base fiscal year (as defined
10 in paragraph (6)) to the midpoint of the
11 fiscal year preceding the first reform year.

12 “(ii) PROJECTED MEDICAL CARE COM-
13 PONENT OF CPI FOR THE FIRST REFORM
14 YEAR.—The percentage increase in the
15 projected medical care component of the
16 Consumer Price Index for all urban con-
17 sumers (U.S. city average) from the mid-
18 point of the previous fiscal year referred to
19 in clause (i) to the midpoint of the first re-
20 form year.

21 “(B) SECOND AND THIRD REFORM
22 YEARS.—The beneficiary-based quarterly
23 amount for a State for a category for quarters
24 in the second reform year or the third reform
25 year is equal to the beneficiary-based quarterly

1 amount under this paragraph for such State
2 and category for the previous reform year in-
3 creased by the per beneficiary percentage in-
4 crease (as defined in subparagraph (E)) for
5 such category and reform year.

6 “(C) FOURTH THROUGH TENTH REFORM
7 YEARS.—The beneficiary-based quarterly
8 amount for a State for a category for quarters
9 in a reform year beginning with the fourth re-
10 form year and ending with the tenth reform
11 year is—

12 “(i) in the case of a State that is a
13 high per beneficiary State or a low per
14 beneficiary State (as defined in paragraph
15 (4)(B)(iii)) for the category, the amount
16 determined under clause (i) or (ii) of para-
17 graph (4)(B) for such State, category, and
18 reform year; or

19 “(ii) in the case of any other State,
20 the beneficiary-based quarterly amount
21 under this paragraph for such State and
22 category for the previous reform year in-
23 creased by the per beneficiary percentage
24 increase for such category and reform
25 year.

1 “(D) ELEVENTH REFORM YEAR AND SUB-
 2 SEQUENT REFORM YEARS.—The beneficiary-
 3 based quarterly amount for a State for a cat-
 4 egory for quarters in a reform year beginning
 5 with the eleventh reform year is equal to the
 6 beneficiary-based quarterly amount under this
 7 paragraph for such State and category for the
 8 previous reform year increased by the per bene-
 9 ficiary percentage increase for such category
 10 and reform year.

11 “(E) ANNUAL PERCENTAGE INCREASE BE-
 12 GINNING WITH SECOND REFORM YEAR.—For
 13 purposes of this subsection, the term ‘per bene-
 14 ficiary percentage increase’ means, for a reform
 15 year, the sum of—

16 “(i) the projected percentage change
 17 in nominal gross domestic product from
 18 the midpoint of the previous reform year to
 19 the midpoint of the reform year for which
 20 the percentage increase is being applied;
 21 and

22 “(ii) one percentage point.

23 “(2) BASE PER BENEFICIARY, PER CATEGORY
 24 AMOUNT FOR EACH STATE.—

25 “(A) AVERAGE PER CATEGORY.—

1 “(i) IN GENERAL.—The Secretary
2 shall determine, consistent with this para-
3 graph and paragraph (3), a base per bene-
4 ficiary, per category amount for each of
5 the 50 States and the District of Columbia
6 equal to the average amount, per Medicaid
7 beneficiary, of Federal payments under
8 this title, including payments attributable
9 to disproportionate share hospital pay-
10 ments under section 1923, for each of the
11 categories of beneficiaries under subsection
12 (b)(2) for the base fiscal year for each of
13 the 50 States and the District of Colum-
14 bia.

15 “(ii) BEST AVAILABLE DATA.—The
16 determination under clause (i) shall ini-
17 tially be estimated by the Secretary, based
18 upon the best available data at the time
19 the determination is made.

20 “(iii) UPDATES.—The determination
21 under clause (i) shall be updated by the
22 Secretary on an annual basis based upon
23 improved data. The Secretary shall adjust
24 the amounts under subsection (a)(1)(A) to

1 reflect changes in the amounts so deter-
2 mined based on such updates.

3 “(B) EXCLUSION OF PASS-THROUGH PAY-
4 MENTS.—In computing base per beneficiary,
5 per category amounts under subparagraph
6 (A)(i) the Secretary shall exclude payments de-
7 scribed in subsection (a)(4).

8 “(C) STANDARDIZATION.—

9 “(i) IN GENERAL.—In computing each
10 such amount, the Secretary shall stand-
11 ardize the amount in order to remove the
12 variation attributable to the following:

13 “(I) RISK FACTORS.—Such risk
14 factors as age, health and disability
15 status (including high cost medical
16 conditions), gender, institutional sta-
17 tus, and such other factors as the
18 Secretary determines to be appro-
19 priate, so as to ensure actuarial
20 equivalence.

21 “(II) GEOGRAPHIC.—Variations
22 in costs on a county-by-county basis.

23 “(ii) METHOD OF STANDARDIZA-
24 TION.—

1 “(I) CONSULTATION IN DEVEL-
2 OPMENT OF RISK STANDARDIZA-
3 TION.—In developing the methodology
4 for risk standardization for purposes
5 of clause (i)(I), the Secretary shall
6 consult with the Medicaid and CHIP
7 Payment and Access Commission, the
8 Medicare Payment Advisory Commis-
9 sion, and the National Association of
10 Medicaid Directors.

11 “(II) METHOD FOR RISK STAND-
12 ARDIZATION.—In carrying out clause
13 (i)(I), the Secretary may apply the
14 hierarchal condition category method-
15 ology under section 1853(a)(1)(C). If
16 the Secretary uses such methodology,
17 the Secretary shall adjust the applica-
18 tion of such methodology to take into
19 account the differences in services
20 provided under this title compared to
21 title XVIII, such as the coverage of
22 long term care, pregnancy, and pedi-
23 atric services.

24 “(III) METHOD FOR GEOGRAPHIC
25 STANDARDIZATION.—The Secretary

1 shall apply the standardization under
2 clause (i)(II) in a manner similar to
3 that applied under section
4 1853(c)(4)(A)(iii).

5 “(iii) APPLICATION ON A NATIONAL,
6 BUDGET NEUTRAL BASIS.—The standard-
7 ization under clause (i) shall be designed
8 and implemented on a uniform national
9 basis and shall be budget neutral so as to
10 not result in any aggregate change in pay-
11 ments under subsection (a).

12 “(iv) RESPONSE TO NEW RISK.—Sub-
13 ject to clause (iii), the Secretary may ad-
14 just the standardization under clause (i) to
15 respond promptly to new instances of com-
16 municable diseases and other public health
17 hazards.

18 “(v) REFERENCE TO APPLICATION OF
19 RISK ADJUSTMENT.—For rules related to
20 the application of risk adjustment to
21 amounts under subsection (a)(1)(A), see
22 subsection (e).

23 “(D) ADJUSTMENT FOR TEMPORARY FMAP
24 INCREASES.—In computing each base per bene-
25 ficiary, per category amounts under subpara-

graph (A)(i) the Secretary shall disregard portions of payments that are attributable to a temporary increase in the Federal matching rates, including those attributable to the following:

“(i) PPACA DISASTER FMAP.—Section 1905(aa).

“(ii) ARRA.—Section 5001 of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 1396d note).

“(iii) EXTRAORDINARY EMPLOYER PENSION CONTRIBUTION.—Section 614 of the Children’s Health Insurance Program Reauthorization Act of 2009 (42 U.S.C. 1396d note).

“(3) ALLOCATION OF NONMEDICAL ASSISTANCE PAYMENTS.—The Secretary shall establish rules for the allocation of payments under this title (other than those payments described in paragraph (1) or (5) of section 1903(a) and including such payments attributable to section 1923)—

“(A) among different categories of beneficiaries; and

1 “(B) between payments included under
 2 subsection (a)(1) and payments described in
 3 subsection (a)(4).

4 “(4) TRANSITION TO A CORRIDOR AROUND THE
 5 NATIONAL AVERAGE.—

6 “(A) DETERMINATION OF NATIONAL AVER-
 7 AGE BASE PER BENEFICIARY, PER CATEGORY
 8 AMOUNT.—Subject to subparagraph (C), the
 9 Secretary shall determine a national average
 10 base per beneficiary, per category amount equal
 11 to the average of the base per beneficiary, per
 12 category amounts for each of the 50 States and
 13 the District of Columbia determined under
 14 paragraph (2), weighted by the average number
 15 of beneficiaries in each such category and State
 16 as determined by the Secretary consistent with
 17 subsection (d) for the base fiscal year.

18 “(B) TRANSITION ADJUSTMENT.—

19 “(i) HIGH PER BENEFICIARY
 20 STATES.—In the case of a high per bene-
 21 ficiary State (as defined in clause (iii)(I))
 22 for a category, the beneficiary-based quar-
 23 terly amount for such State and category
 24 for a quarter in a reform year (beginning
 25 with the fourth reform year and ending

1 with the tenth reform year) is equal to the
2 sum of—

3 “(I) the product of the State-spe-
4 cific factor for such reform year (as
5 defined in clause (iv)) and the bene-
6 ficiary-based quarterly amount that
7 would otherwise be determined under
8 paragraph (1) for such State and cat-
9 egory if the State were a State de-
10 scribed in clause (ii) of paragraph
11 (1)(C), instead of a State described in
12 clause (i) of such paragraph; and

13 “(II) the product of 1 minus the
14 State-specific factor for such reform
15 year and the beneficiary-based quar-
16 terly amount that would otherwise be
17 determined under paragraph (1) for a
18 State and category if the base per
19 beneficiary, per category amount de-
20 termined under paragraph (2) for the
21 State and category were equal to 110
22 percent of the national average base
23 per beneficiary, per category amount
24 determined under subparagraph (A)
25 for such category.

1 “(ii) LOW PER BENEFICIARY
2 STATES.—In the case of a low per bene-
3 ficiary State (as defined in clause (iii)(II))
4 for a category, the beneficiary-based quar-
5 terly amount for such State and category
6 for a quarter in a reform year (beginning
7 with the fourth reform year and ending
8 with the tenth reform year) is equal to the
9 sum of—

10 “(I) the product of the State-spe-
11 cific factor for such reform year and
12 the beneficiary-based quarterly
13 amount that would otherwise be deter-
14 mined under paragraph (1) for such
15 State and category if the State were
16 a State described in clause (ii) of
17 paragraph (1)(C), instead of a State
18 described in clause (i) of such para-
19 graph; and

20 “(II) the product of 1 minus the
21 State-specific factor for such reform
22 year and the beneficiary-based quar-
23 terly amount that would otherwise be
24 determined under paragraph (1) for a
25 State and category if the base per

1 beneficiary, per category amount de-
2 termined under paragraph (2) for the
3 State and category were equal to 90
4 percent of the national average base
5 per beneficiary, per category amount
6 determined under subparagraph (A)
7 for such category.

8 “(iii) HIGH AND LOW PER BENE-
9 FICIARY STATES DEFINED.—In this sub-
10 paragraph:

11 “(I) HIGH PER BENEFICIARY
12 STATE.—The term ‘high per bene-
13 ficiary State’ means, with respect to a
14 category, a State for which the base
15 per beneficiary, per category amount
16 determined under paragraph (2) for
17 such category is greater than 110 per-
18 cent of the national average base per
19 beneficiary, per category amount de-
20 termined under subparagraph (A) for
21 such category.

22 “(II) LOW PER BENEFICIARY
23 STATE.—The term ‘low per bene-
24 ficiary State’ means, with respect to a
25 category, a State for which the base

1 per beneficiary, per category amount
 2 determined under paragraph (2) for
 3 such category is less than 90 percent
 4 of the national average base per bene-
 5 ficiary, per category amount deter-
 6 mined under subparagraph (A) for
 7 such category.

8 “(iv) STATE-SPECIFIC FACTOR.—In
 9 this subparagraph, the term ‘State-specific
 10 factor’ means—

11 “(I) for the fourth reform year,
 12 $\frac{7}{8}$; and

13 “(II) for a subsequent reform
 14 year, the State-specific factor under
 15 this clause for the previous reform
 16 year minus $\frac{1}{8}$.

17 “(C) NO ADDITIONAL EXPENDITURES.—

18 “(i) DETERMINATION OF INCREASE IN
 19 FEDERAL EXPENDITURES.—For each cat-
 20 egory for each reform year (beginning with
 21 the fourth reform year and ending with the
 22 tenth reform year), the Secretary shall de-
 23 termine whether the application of this
 24 paragraph—

1 “(I) to the category for the re-
2 form year will result in an aggregate
3 increase in the aggregate Federal ex-
4 penditures under subsection (a); and

5 “(II) to all the categories for the
6 reform year will result in a net aggre-
7 gate increase in the aggregate Federal
8 expenditures under subsection (a).

9 “(ii) ADJUSTMENT.—If the Secretary
10 determines under clause (i)(II) that the
11 application of this paragraph to all the cat-
12 egories for a reform year will result in a
13 net aggregate increase in the aggregate
14 Federal expenditures under subsection (a),
15 the Secretary shall reduce the national av-
16 erage base per beneficiary, per category
17 amount computed under subparagraph (A)
18 for each of the categories determined
19 under clause (i)(I) for which there will be
20 an aggregate increase in the aggregate
21 Federal expenditures under subsection (a)
22 by such uniform percentage as will ensure
23 that there is no net aggregate Federal ex-
24 penditure increase described in clause
25 (i)(II) for the reform year.

1 “(5) REPORTS ON PER BENEFICIARY RATES;
2 APPEALS.—

3 “(A) REPORT TO STATES.—Not later than
4 8 months after the date of the enactment of
5 this section, the Secretary shall submit to each
6 State the Secretary’s initial determination of—

7 “(i) the base per beneficiary, per cat-
8 egory amounts under paragraph (2) for
9 such State; and

10 “(ii) the national average base per
11 beneficiary, per category amounts under
12 paragraph (4)(A).

13 “(B) OPPORTUNITY TO APPEAL.—Not
14 later than 3 months after the date a State re-
15 ceives notice of the Secretary’s initial deter-
16 mination of such base per beneficiary, per cat-
17 egory amounts for such State under subpara-
18 graph (A)(i), the State may file with the Sec-
19 retary, in a form and manner specified by the
20 Secretary, an appeal of such determination.

21 “(C) DETERMINATION ON APPEAL.—Not
22 later than 3 months after receiving such an ap-
23 peal, the Secretary shall make a final deter-
24 mination on such amounts for such State. If no
25 such appeal is received for a State, the Sec-

1 retary’s initial determination under subpara-
2 graph (A)(i) shall become final.

3 “(6) BASE FISCAL YEAR DEFINED.—In this
4 section, the term ‘base fiscal year’ means the latest
5 fiscal year, ending before the date of the enactment
6 of this section, for which the Secretary determines
7 that adequate data are available to make the com-
8 putations required under this subsection.

9 “(d) NOT COUNTING INDIVIDUALS TO ACCOUNT FOR
10 EXCLUDED PAYMENTS.—Under rules specified by the
11 Secretary, individuals shall not be counted as Medicaid
12 beneficiaries for purposes of subsection (b)(1)(B) and sub-
13 section (c)(2)(A) in proportion to the extent that such in-
14 dividuals are receiving medical assistance for which pay-
15 ments described under subsection (a)(4)(A) are made.

16 “(e) RISK ADJUSTMENT.—

17 “(1) IN GENERAL.—The amount under sub-
18 section (a)(1)(A) shall be adjusted under this sub-
19 section in an appropriate manner, specified by the
20 Secretary and consistent with paragraph (2), to take
21 into account—

22 “(A) the factors described in subsection
23 (c)(2)(C)(i)(I) within a category of bene-
24 ficiaries; and

1 “(B) variations in costs on a county-by-
 2 county basis for medical assistance and admin-
 3 istrative expenses.

4 “(2) METHOD OF ADJUSTMENT.—

5 “(A) IN GENERAL.—The adjustments
 6 under paragraph (1) shall be made in a manner
 7 similar to the manner in which similar adjust-
 8 ments are made under subsection (c)(2)(C) and
 9 consistent with the requirements of clause (iii)
 10 of such subsection and subparagraph (B).

11 “(B) BIENNIAL UPDATE OF RISK ADJUST-
 12 MENT METHODOLOGY.—In applying clause
 13 (i)(I) of subsection (c)(2)(C) for purposes of
 14 subparagraph (A), the Secretary shall, in con-
 15 sultation with the entities described in clause
 16 (ii)(I) of such subsection, update the risk ad-
 17 justment methodology applied as appropriate
 18 not less often than every 2 years.

19 “(f) CHRONIC CARE QUALITY BONUS PAYMENTS.—

20 “(1) DETERMINATION OF BONUS PAYMENTS.—

21 If the Secretary determines that, based on the re-
 22 ports under paragraph (5), with respect to cat-
 23 egories of chronic disease for which chronic care per-
 24 formance targets had been established under para-
 25 graph (3) for each category of Medicaid beneficiaries

1 specified under subsection (b)(2) such targets have
2 been met by a State for a reform year, the Secretary
3 shall make an additional payment to such State in
4 the amount specified in paragraph (6) for each quar-
5 ter in the succeeding reform year. Such payments
6 shall be made in a manner specified by the Secretary
7 and may only be used consistent with subsection
8 (a)(3).

9 “(2) IDENTIFICATION OF CATEGORIES OF
10 CHRONIC DISEASE.—The Secretary shall determine
11 the categories of chronic disease for which bonus
12 payments may be available under this subsection for
13 each category of Medicaid beneficiaries.

14 “(3) ADOPTION OF QUALITY MEASUREMENT
15 SYSTEM AND IDENTIFICATION OF PERFORMANCE
16 TARGETS.—

17 “(A) SYSTEM AND DATA.—With respect to
18 the categories of chronic disease under para-
19 graph (2), the Secretary shall adopt a quality
20 measurement system that uses data described
21 in paragraph (4) and is similar to the Five-Star
22 Quality Rating System used to indicate the per-
23 formance of Medicare Advantage plans under
24 part C of title XVIII.

1 “(B) TARGETS.—Using such system and
2 data, the Secretary shall establish for each re-
3 form year the chronic care performance targets
4 for purposes of the payments under paragraph
5 (1). Such performance targets shall be estab-
6 lished in consultation with States, associations
7 representing individuals with chronic illnesses,
8 entities providing treatment to such individuals
9 for such chronic illnesses, and other stake-
10 holders, including the National Association of
11 Medicaid Directors and the National Governors
12 Association.

13 “(4) DATA TO BE USED.—The data to be used
14 under paragraph (3) shall include—

15 “(A) data collected through methods such
16 as—

17 “(i) the ‘Healthcare Effectiveness
18 Data and Information Set’ (also known as
19 ‘HEDIS’) (or an appropriate successor
20 performance measurement tool);

21 “(ii) the ‘Consumer Assessment of
22 Healthcare Providers and Systems’ (also
23 known as ‘CAHPS’) (or an appropriate
24 successor performance measurement tool);
25 and

1 “(iii) the ‘Health Outcomes Survey’
2 (also known as ‘HOS’) (or an appropriate
3 successor performance measurement tool);
4 and
5 “(B) other data collected by the State.

6 “(5) REPORTS.—

7 “(A) IN GENERAL.—Each State shall col-
8 lect, analyze, and report to the Secretary, at a
9 frequency and in a manner to be established by
10 the Secretary, data described in paragraph (4)
11 that permit the Secretary to monitor the State’s
12 performance relative to the chronic care per-
13 formance targets established under paragraph
14 (3).

15 “(B) REVIEW AND VERIFICATION.—The
16 Secretary may review the data collected by the
17 State under subparagraph (A) to verify the
18 State’s analysis of such data with respect to the
19 performance targets under paragraph (3).

20 “(6) AMOUNT OF BONUS PAYMENTS.—

21 “(A) IN GENERAL.—Subject to subpara-
22 graphs (B) and (C), with respect to each cat-
23 egory of Medicaid beneficiaries, in the case of
24 a State that the Secretary determines, based on
25 the chronic care performance targets set under

1 paragraph (3) for a reform year for such cat-
2 egory, performs—

3 “(i) in the top five States in such cat-
4 egory, subject to subparagraph (C)(ii), the
5 amount of the bonus for each quarter in
6 the succeeding reform year shall be 10 per-
7 cent of the payment amount otherwise paid
8 to the State under subsection (a) for indi-
9 viduals enrolled under the plan within such
10 category;

11 “(ii) in the next five States in such
12 category, subject to subparagraph (C)(ii),
13 the amount of the bonus for each such
14 quarter shall be 5 percent of the payment
15 amount otherwise paid to the State under
16 subsection (a) for individuals enrolled
17 under the plan within such category;

18 “(iii) in the next five States in such
19 category, subject to clauses (i) and (iii) of
20 subparagraph (C), the amount of the
21 bonus for each such quarter shall be 3 per-
22 cent of the payment amount otherwise paid
23 to the State under subsection (a) for indi-
24 viduals enrolled under the plan within such
25 category;

1 “(iv) in the next five States in such
 2 category, subject to clauses (i) and (iii) of
 3 subparagraph (C), the amount of the
 4 bonus for each such quarter shall be 2 per-
 5 cent of the payment amount otherwise paid
 6 to the State under subsection (a) for indi-
 7 viduals enrolled under the plan within such
 8 category; and

9 “(v) in the next five States in such
 10 category, subject to clauses (i) and (iii) of
 11 subparagraph (C), the amount of the
 12 bonus for each such quarter shall be 1 per-
 13 cent of the payment amount otherwise paid
 14 to the State under subsection (a) for indi-
 15 viduals enrolled under the plan within such
 16 category.

17 “(B) AGGREGATE ANNUAL LIMIT FOR
 18 EACH CATEGORY OF MEDICAID BENE-
 19 FICIARIES.—

20 “(i) IN GENERAL.—In no case may
 21 the aggregate amount of bonuses under
 22 this subsection for quarters in a reform
 23 year for a category of Medicaid bene-
 24 ficiaries exceed the limit specified in clause
 25 (ii) for the reform year.

1 “(ii) LIMIT.—The limit specified in
2 this clause—

3 “(I) for the second reform year is
4 equal to \$250,000,000; or

5 “(II) for a subsequent reform
6 year is equal to the limit specified in
7 this clause for the previous reform
8 year increased by the per beneficiary
9 percentage increase determined under
10 paragraph (1)(E) of subsection (c).

11 “(C) LIMITATION AND PRORATION OF BO-
12 NUSES BASED ON APPLICATION OF AGGREGATE
13 LIMIT.—

14 “(i) NO BONUS FOR THIRD OR SUBSE-
15 QUENT TIERS UNLESS AGGREGATE LIMIT
16 NOT REACHED ON FIRST TWO TIERS.—No
17 bonus shall be payable under clause (iii),
18 (iv), or (v) of subparagraph (A) for a cat-
19 egory of Medicaid beneficiaries for a quar-
20 ter in a reform year unless the aggregate
21 amount of bonuses under clauses (i) and
22 (ii) of such subparagraph for such category
23 and reform year is less than the limit spec-
24 ified in subparagraph (B)(ii) for the re-
25 form year.

1 “(ii) PRORATION FOR FIRST TWO
2 TIERS.—If the aggregate amount of bo-
3 nuses under clauses (i) and (ii) of subpara-
4 graph (A) for a category of Medicaid bene-
5 ficiaries for quarters in a reform year ex-
6 ceeds the limit specified in subparagraph
7 (B)(ii) for the reform year, the amount of
8 each such bonus shall be prorated in a
9 manner so the aggregate amount of such
10 bonuses is equal to such limit.

11 “(iii) PRORATION FOR NEXT THREE
12 TIERS.—If the aggregate amount of bo-
13 nuses under clauses (i) and (ii) of subpara-
14 graph (A) for a category of Medicaid bene-
15 ficiaries for quarters in a reform year is
16 less than the limit specified in subpara-
17 graph (B)(ii) for the reform year, but the
18 aggregate amount of bonuses under clauses
19 (i) through (v) of subparagraph (A) for the
20 category and such quarters in the reform
21 year exceeds the limit specified in subpara-
22 graph (B)(ii) for the reform year, the
23 amount of each bonus in clauses (iii), (iv),
24 and (v) of subparagraph (A) shall be pro-
25 rated in a manner so the aggregate

1 amount of all the bonuses under subpara-
2 graph (A) is equal to such limit.

3 “(g) STATE OPTION FOR RECEIVING MEDICARE PAY-
4 MENTS FOR FULL-BENEFIT DUAL ELIGIBLE INDIVID-
5 UALS.—

6 “(1) IN GENERAL.—Under this subsection a
7 State may elect for quarters beginning on or after
8 the implementation date in a reform year to receive
9 payment from the Secretary under paragraph (3).
10 As a condition of receiving such payment, the State
11 shall agree to provide to full-benefit dual eligible in-
12 dividuals eligible for medical assistance under the
13 State plan—

14 “(A) the medical assistance to which such
15 eligible individuals would otherwise be entitled
16 under this title; and

17 “(B) any items and services which such eli-
18 gible individuals would otherwise receive under
19 title XVIII.

20 “(2) PROVIDER PAYMENT REQUIREMENT.—

21 “(A) IN GENERAL.—A State electing the
22 option under this subsection shall provide pay-
23 ment to health care providers for the items and
24 services described under paragraph (1)(B) at a
25 rate that is not less than the rate at which pay-

1 ments would be made to such providers for such
2 items and services under title XVIII.

3 “(B) FLEXIBILITY IN PAYMENT METH-
4 ODS.—Nothing in subparagraph (A) shall be
5 construed as preventing a State from using al-
6 ternative payment methodologies (such as bun-
7 dled payments or the use of accountable care
8 organizations (as such term is used in section
9 1899)) for purposes of making payments to
10 health care providers for items and services pro-
11 vided to dual eligible individuals in the State
12 under the option under this subsection.

13 “(3) PAYMENTS TO STATES IN LIEU OF MEDI-
14 CARE PAYMENTS.—With respect to a full-benefit
15 dual eligible individual, in the case of a State that
16 elects the option under paragraph (1) for quarters in
17 a reform year—

18 “(A) the Secretary shall not make any pay-
19 ment under title XVIII for items and services
20 furnished to such individual for such quarters;
21 and

22 “(B) the Secretary shall pay to the State,
23 in addition to the amounts paid to such State
24 under subsection (a), the amount that the Sec-
25 retary would, but for this subsection, otherwise

1 pay under title XVIII for items and services
2 furnished to such an individual in such State
3 for such quarters.

4 “(4) FULL-BENEFIT DUAL ELIGIBLE INDIVIDUAL
5 DEFINED.—In this subsection, the term
6 ‘full-benefit dual eligible individual’ means an indi-
7 vidual who meets the requirements of section
8 1935(c)(6)(A)(ii).

9 “(h) AUDITS.—The Secretary shall conduct such au-
10 dits on the number and classification of Medicaid bene-
11 ficiaries under such subsections and expenditures under
12 this section as may be necessary to ensure appropriate
13 payments under this section.

14 “(i) TREATMENT OF WAIVERS.—

15 “(1) NO IMPACT ON CURRENT WAIVERS.—In
16 the case of a waiver of requirements of this title pur-
17 suant to section 1115 or other law that is in effect
18 as of the date of the enactment of this section, noth-
19 ing in this section shall be construed to affect such
20 waiver for the period of the waiver as approved as
21 of such date.

22 “(2) APPLICATION OF BUDGET NEUTRALITY TO
23 SUBSEQUENT WAIVERS AND RENEWALS TAKING SEC-
24 TION INTO ACCOUNT.—In the case of a waiver of re-
25 quirements of this title pursuant to section 1115 or

1 other law that is approved or renewed after the date
2 of the enactment of this section, to the extent that
3 such approval or renewal is conditioned upon a dem-
4 onstration of budget neutrality, budget neutrality
5 shall be determined taking into account the applica-
6 tion of this section.

7 “(j) REPORT TO CONGRESS.—Not later than Janu-
8 ary 1 of the second reform year, the Secretary shall submit
9 to Congress a report on the implementation of this section.

10 “(k) DEFINITIONS.—In this section:

11 “(1) IMPLEMENTATION DATE.—The term ‘im-
12 plementation date’ means—

13 “(A) July 1, 2018, if this section is en-
14 acted on or before July 1, 2017; or

15 “(B) July 1, 2019, if this section is en-
16 acted after July 1, 2017.

17 “(2) REFORM YEARS.—

18 “(A) The term ‘reform year’ means a fiscal
19 year beginning with the first reform year.

20 “(B) The term ‘first reform year’ means
21 the fiscal year in which the implementation date
22 occurs.

23 “(C) The terms ‘second’, ‘third’, and suc-
24 cessive similar terms mean, with respect to a
25 reform year, the second, third, or successive re-

1 form year, respectively, succeeding the first re-
2 form year.”.

3 (b) CONFORMING AMENDMENTS.—

4 (1) CONTINUED APPLICATION OF CLAWBACK
5 PROVISIONS.—

6 (A) CONTINUED APPLICATION.—Sub-
7 sections (a) and (c)(1)(C) of section 1935 of
8 such Act (42 U.S.C. 1396u–5) are each amend-
9 ed by inserting “or 1903A(a)” after “1903(a)”.

10 (B) TECHNICAL AMENDMENT.—Section
11 1935(d)(1) of the Social Security Act (42
12 U.S.C. 1396u–5(d)(1)) is amended by inserting
13 “except as provided in section 1903A(g)” after
14 “any other provision of this title”.

15 (2) PAYMENT RULES UNDER SECTION 1903.—

16 (A) Section 1903(a) of the Social Security
17 Act (42 U.S.C. 1396b(a)) is amended, in the
18 matter before paragraph (1), by inserting “and
19 section 1903A” after “except as otherwise pro-
20 vided in this section”.

21 (B) Section 1903(d) of such Act (42
22 U.S.C. 1396b(d)) is amended—

23 (i) in paragraph (1), by inserting
24 “and under section 1903A” after “sub-
25 sections (a) and (b)”;

1 (ii) in paragraph (2)—

2 (I) in subparagraph (A), by in-
3 serting “or section 1903A” after “was
4 made under this section”; and

5 (II) in subparagraph (B), by in-
6 serting “or section 1903A” after
7 “under subsection (a)”; and

8 (iii) in paragraph (4)—

9 (I) by striking “under this sub-
10 section” and inserting “, with respect
11 to this section or section 1903A,
12 under this subsection”; and

13 (II) by striking “under this sec-
14 tion” and inserting “under the respec-
15 tive section”; and

16 (iv) in paragraph (5), by inserting “or
17 section 1903A” after “overpayment under
18 this section”.

19 (3) CONFORMING WAIVER AUTHORITY.—Section
20 1115(a)(2)(A) of the Social Security Act (42 U.S.C.
21 1315(a)(2)(A)) is amended by striking “or 1903”
22 and inserting “1903, or 1903A”.

23 (4) REPORT ON ADDITIONAL CONFORMING
24 AMENDMENTS NEEDED.—Not later than 6 months
25 after the date of the enactment of this Act, the Sec-

1 retary of Health and Human Services shall submit
2 to Congress a report that includes a description of
3 any additional technical and conforming amend-
4 ments to law that are required to properly carry out
5 this Act.

6 **TITLE V—INCREASING PRICE**
7 **TRANSPARENCY AND FREE-**
8 **DOM OF PRACTICE**

9 **SEC. 501. ENSURING ACCESS TO EMERGENCY SERVICES**
10 **WITHOUT EXCESSIVE CHARGES FOR OUT-OF-**
11 **NETWORK SERVICES.**

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

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

16 “(5) ENFORCEMENT WITH RESPECT TO EXCES-
17 SIVE CHARGES.—A hospital, physician, or other enti-
18 ty that violates the requirements of subsection (j)(1)
19 with respect to the furnishing of items and services
20 is subject to a civil money penalty of not more than
21 \$25,000 for each such violation. The provisions of
22 section 1128A (other than subsections (a) and (b))
23 shall apply to a civil money penalty under this para-
24 graph in the same manner as such provisions apply

1 with respect to a penalty or proceeding under section
2 1128A(a).”; and

3 (2) by adding at the end the following new sub-
4 section:

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

7 “(1) IN GENERAL.—If items or services to
8 screen or treat an emergency medical condition are
9 furnished under this section in a participating hos-
10 pital with respect to an individual and the individual
11 has not, directly or through a health insurance
12 issuer, group health plan, or other third party, nego-
13 tiated a payment rate for such items and services,
14 subject to paragraph (2), the charges imposed for
15 such items and services may not be in excess of the
16 following:

17 “(A) PHYSICIANS’ AND OTHER PROFES-
18 SIONAL SERVICES.—For physicians’ services or
19 services of a health care provider to which sec-
20 tion 223(e)(9) of the Internal Revenue Code of
21 1986 applies (and including drugs and
22 biologicals furnished in conjunction with and
23 billed as part of such services), the lesser of—

24 “(i) the cash price for such services
25 posted pursuant to such section; or

1 “(ii) 85 percent of the usual, cus-
2 tomary, and reasonable (UCR) charge for
3 such services, as determined under rules
4 established by the department of insurance
5 for the State in which the services are fur-
6 nished.

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

13 “(i) the cash price for such services
14 posted pursuant to section 223(e)(9) of the
15 Internal Revenue Code of 1986; or

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

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

1 “(i) twice the acquisition cost to the
 2 hospital or other provider for the dose in-
 3 volved; or

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

6 The dollar amount in clause (ii) shall be in-
 7 creased from year to year (beginning with the
 8 year after the first year in which this subsection
 9 applies) by the same percentage as the percent-
 10 age increase in the consumer price index for all
 11 urban consumers (all items; U.S. city average)
 12 for the year involved (as determined by the Sec-
 13 retary). Any such dollar amount as so increased
 14 that is not a multiple of \$5 shall be rounded to
 15 the nearest multiple of \$5 (or, if a multiple of
 16 \$2.50, to the next highest multiple of \$5).

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

19 “(i) the cash price for such items and
 20 services posted pursuant to section
 21 223(e)(9) of the Internal Revenue Code of
 22 1986; or

23 “(ii) 110 percent of the payment basis
 24 that would be applicable to payment for
 25 such items and services under this title in

1 the case of an individual entitled to bene-
2 fits under part A and enrolled under part
3 B.

4 “(2) SPECIAL RULE FOR ITEMS AND SERVICES
5 FURNISHED AS A BUNDLE.—In the case of items
6 and services for which there is a single price for a
7 group or bundle of such items and services, the max-
8 imum charge permitted under paragraph (1) may
9 not exceed the lesser of—

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

12 “(B) the aggregate of the maximum
13 charges permitted under paragraph (1) with re-
14 spect to items and services included in such
15 bundle.”.

16 (b) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to charges imposed for items and
18 services furnished on or after January 1, 2018.

19 **SEC. 502. PUBLISHING OF CASH PRICE FOR CARE PAID**
20 **THROUGH HEALTH SAVINGS ACCOUNTS.**

21 (a) HEALTH SAVINGS ACCOUNTS.—Section 223(f) of
22 the Internal Revenue Code of 1986 is amended by adding
23 at the end the following new paragraph:

24 “(9) CASH PRICE TRANSPARENCY REQUIRED
25 FOR PAYMENTS TO HEALTH CARE PROVIDERS.—

1 “(A) IN GENERAL.—A payment to a health
2 care provider with respect to the furnishing of
3 health care items and services by such provider
4 shall not be treated as a qualified medical ex-
5 pense unless health care provider provides for
6 continuing disclosure (such as through posting
7 on a publicly accessible website) of the cash
8 price the health care provider charges for the
9 furnishing of such items and services.

10 “(B) FORM OF DISCLOSURE.—The disclo-
11 sure of prices under this subsection shall be in
12 a form and manner specified by the Secretary
13 of Health and Human Services, in consultation
14 with the Secretary, and shall be designed—

15 “(i) to establish a single price for re-
16 lated items and services in a manner simi-
17 lar to the manner in which pricing and
18 payment for such items and services is pro-
19 vided under the Medicare program under
20 title XVIII of the Social Security Act, and

21 “(ii) to make it easy for consumers to
22 compare the prices for similar items and
23 services furnished by different providers.

24 “(C) FAILURE TO FURNISH SERVICES OR
25 CHARGE IN EXCESS OF STATED PRICE.—A

1 health care provider shall be treated as not
2 meeting the requirement of subparagraph (A),
3 in the case of items and services for which the
4 provider is disclosing a cash price, if the pro-
5 vider—

6 “(i) refuses to furnish such items or
7 services at the price listed, or

8 “(ii) charges more than the price list-
9 ed for the furnishing of the items and serv-
10 ices.”.

11 (b) ROTH HSA.—Section 530A(c)(4) of such Code,
12 as added by section 201(a) of this Act, is amended by add-
13 ing at the end the following new subparagraph:

14 “(E) Section 223(f) (relating to cash price
15 transparency required for payments to health
16 care providers).”.

17 (c) ENFORCEMENT.—If the Secretary of Health and
18 Human Services determines that a health care provider
19 has not provided for continuing disclosure of the cash
20 price of health care provider charges under section
21 223(f)(9) of the Internal Revenue Code of 1986, the Sec-
22 retary may instruct the Secretary of the Treasury that
23 payments made to such provider shall be not treated, for
24 purposes of section 223 of the Internal Revenue Code of

1 1986, as an amount used for a qualified medical expense
 2 for a period of not to exceed 1 year.

3 (d) EFFECTIVE DATE.—The amendments made by
 4 this section shall apply to taxable years beginning after
 5 December 31, 2017.

6 **SEC. 503. LIBERATING THE LOCAL PRACTICE OF HEALTH**
 7 **CARE.**

8 (a) WAIVING NATIONAL RESTRICTIONS ON PHYSI-
 9 CIAN-OWNED FACILITIES.—Section 1877 of the Social Se-
 10 curity Act (42 U.S.C. 1395nn) is amended by adding at
 11 the end the following new subsection:

12 “(j) WAIVER AUTHORITY.—A physician or other enti-
 13 ty may apply to the Secretary to waive any provision of
 14 this section and the Secretary may waive such provision
 15 with respect to such physician or entity if the Secretary
 16 determines that such waiver would—

17 “(1) increase competition within the health care
 18 market;

19 “(2) reduce the costs of health care; and

20 “(3) increase the quality of health care.”.

21 (b) REMOVING CERTAIN STATE AND LOCAL LICEN-
 22 SURE OR CERTIFICATION RESTRICTIONS.—

23 (1) APPLICATION FOR WAIVER OF RESTRIC-
 24 TIONS.—An individual who is required to be licensed
 25 or certified by a State as a condition of furnishing

1 items or services as a health care professional (as
2 defined by the Secretary of Health and Human
3 Services) may submit to the Secretary an application
4 to waive any condition of such licensure or certifi-
5 cation.

6 (2) STANDARD.—The Secretary may grant a
7 waiver submitted under paragraph (1) if the Sec-
8 retary determines such waiver would—

9 (A) increase competition within the health
10 care market;

11 (B) reduce the costs of health care; and

12 (C) increase the quality of health care.

13 (3) PREEMPTION.—In the case of a health care
14 professional granted a waiver under paragraph (2),
15 any requirement with respect to which such waiver
16 is granted is preempted to the extent specified in
17 such waiver.

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