

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.

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## 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

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## 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-



1 including amounts otherwise excluded from  
2 gross income which were paid by or on be-  
3 half of the taxpayer for employer-provided  
4 insurance that constitutes medical care,  
5 over

6 “(ii) the amount of tax imposed by  
7 this chapter for the taxable year (deter-  
8 mined without regard to this section).

9 “(C) FEDERAL PAYROLL TAX SUBSIDY.—

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

13 “(i) the sum of—

14 “(I) the amount of tax that  
15 would have been imposed by chapter  
16 21 with respect to any wages of the  
17 taxpayer paid during the taxable year  
18 had such tax been determined by in-  
19 cluding amounts otherwise excluded  
20 from wages which were paid by or on  
21 behalf of the taxpayer during the tax-  
22 able year for employer-provided insur-  
23 ance that constitutes medical care,  
24 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):

<b>“If the household income (expressed as a percent of poverty line) is:</b>	<b>The applicable dollar amount is:</b>
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 INDI-  
4           VIDUALS 55 OR OLDER.—In the case of an individual  
5           who has attained age 55 before the close of the tax-  
6           able year, the applicable limitation under subpara-  
7           graphs (A) and (B) of paragraph (2) shall be in-  
8           creased by \$1,000.

9           “(4) COORDINATION WITH OTHER CONTRIBU-  
10          TIONS.—The limitation which would (but for this  
11          paragraph) apply under this subsection to an indi-  
12          vidual for any taxable year shall be reduced (but not  
13          below zero) by the sum of—

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

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

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

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-

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

4 “(B) FAILURE TO MAINTAIN CREDITABLE  
5 COVERAGE.—

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

9 “(I) gross income of the indi-  
10 vidual for the taxable year in which  
11 occurs the first month in the testing  
12 period for which such individual is not  
13 an eligible individual is increased by  
14 the aggregate amount of all contribu-  
15 tions to the Roth HSA of the indi-  
16 vidual which could not have been  
17 made but for subparagraph (A), and

18 “(II) the tax imposed by this  
19 chapter for any taxable year on the  
20 individual shall be increased by 10  
21 percent of the amount of such in-  
22 crease.

23 “(ii) EXCEPTION FOR DISABILITY OR  
24 DEATH.—Subclauses (I) and (II) of clause  
25 (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-

1 count beneficiary, amounts paid by such bene-  
2 ficiary for medical care (as defined in section  
3 213(d) as in effect on the day before the date  
4 of the enactment of the World’s Greatest  
5 Healthcare Plan of 2017) for such individual,  
6 the spouse of such individual, and any depend-  
7 ent (as defined in section 152, determined with-  
8 out regard to subsections (b)(1), (b)(2), and  
9 (d)(1)(B) thereof) of such individual, but only  
10 to the extent such amounts are not com-  
11 pensated for by insurance or otherwise.

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

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

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

23 “(ii) a qualified long-term care insur-  
24 ance contract (as defined in section  
25 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

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

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

12 “(f) COST-OF-LIVING ADJUSTMENT.—

13 “(1) IN GENERAL.—In the case of any calendar  
14 year beginning after 2016, the \$5,000 dollar amount  
15 in subsection (b)(2) shall be increased by an amount  
16 equal to—

17 “(A) such dollar amount, multiplied by

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

21 “(i) by substituting ‘calendar year  
22 2015’ for ‘calendar year 1992’ in subpara-  
23 graph (B) thereof, and

24 “(ii) by substituting ‘CPI medical care  
25 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            beneficiary-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-



1           vidual who has an income (as determined  
2           under clause (ii)) that exceeds 100 percent  
3           of the poverty line (as defined in section  
4           2110(c)(5)) applicable to a family of the  
5           size involved.

6           “(ii) DETERMINATION OF INCOME  
7           USING MODIFIED ADJUSTED GROSS IN-  
8           COME WITHOUT ANY 5 PERCENT IN-  
9           CREASE.—In determining income for pur-  
10          poses of clause (i) under section  
11          1902(e)(14) (relating to modified adjusted  
12          gross income), the following rules shall  
13          apply:

14               “(I) APPLICATION OF SPEND  
15               DOWN.—The State shall take into ac-  
16               count the costs incurred for medical  
17               care or for any other type of remedial  
18               care recognized under State law in the  
19               same manner and to the same extent  
20               that such State takes such costs into  
21               account for purposes of section  
22               1902(a)(17).

23               “(II) DISREGARD OF 5 PERCENT  
24               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(e)(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-

1 graph (A)(i) the Secretary shall disregard por-  
2 tions of payments that are attributable to a  
3 temporary increase in the Federal matching  
4 rates, including those attributable to the fol-  
5 lowing:

6 “(i) PPACA DISASTER FMAP.—Sec-  
7 tion 1905(aa).

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

11 “(iii) EXTRAORDINARY EMPLOYER  
12 PENSION CONTRIBUTION.—Section 614 of  
13 the Children’s Health Insurance Program  
14 Reauthorization Act of 2009 (42 U.S.C.  
15 1396d note).

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

22 “(A) among different categories of bene-  
23 ficiaries; 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 (e).

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 INDI-  
5           VIDUAL 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(e)(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)”;

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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