114TH CONGRESS
1ST SESSION

S. 1531

To reform the provision of health insurance coverage by promoting health savings accounts, State-based alternatives to coverage under the Affordable Care Act, and price transparency, in order to promote a more market-based health care system, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 9, 2015

Mr. CASSIDY (for himself, Mr. MCCONNELL, Mr. CORNYN, Ms. COLLINS, Mr. INHOFE, Mr. COATS, Mr. ROUNDS, Mr. VITTER, Mrs. CAPITO, and Mr. WICKER) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To reform the provision of health insurance coverage by promoting health savings accounts, State-based alternatives to coverage under the Affordable Care Act, and price transparency, in order to promote a more market-based health care system, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Patient Freedom Act of 2015".

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

SEC. 2. SENSE OF CONGRESS.

It is the sense of Congress that there is a need for legislation providing temporary transition funding for those who lose health insurance subsidies in the aftermath

of a Supreme Court decision in favor of the plaintiffs-appellants in the case of King v. Burwell.

TITLE I—HEALTH REFORM

SEC. 100. DEFINITIONS.

In this title:

(1) PATIENT-GRANT ELECTING STATE.—The term ''patient-grant electing State'' means an electing State that specifies under section 102(a)(4)(B) that it will carry out section 102(b) itself (and not to have section 102(b) carried out by means of the credit under section 36C of the Internal Revenue Code of 1986).

(2) CHIP.—The term ''CHIP'' means the Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1396 et seq.).

(3) CREDITABLE COVERAGE.—The term ''creditable coverage'' has the meaning given such term in section 2704(c)(1) of the Public Health Service Act (42 U.S.C. 300gg–3(c)(1)), as in effect as of the day before the date of the enactment of this Act.

(4) DEFAULT HEALTH INSURANCE COVERAGE.—The term ''default health insurance coverage'' has the meaning given such term in section 105(c)(2).

(5) DEPOSIT QUALIFYING RESIDENT.—The term ''deposit qualifying resident'' has the meaning given such term in section 102(b)(2).

(6) ELECTING STATE.—The term ''electing State'' means a State that elects under section 101(a)(3) the alternative option described in section 102.

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

(8) HEALTH SAVINGS ACCOUNT; HSA.—The terms ''health savings account'' and ''HSA'' mean a health savings account established under section 223 of the Internal Revenue Code of 1986.

(9) HEALTH SAVINGS DEPOSIT.—The term ''health savings deposit'' means a deposit made into a health savings account pursuant to section 102.

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

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

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

(13) QUALIFIED HEALTH PLAN COVERAGE.—The term ''qualified health plan coverage'' means, with respect to residents of a State, health insurance coverage that meets applicable standards under State law, which standards need not be the same as that previously required of qualified health plans under title I of PPACA, and includes a high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) and includes coverage under a group health plan.

(14) QUALIFIED RESIDENT.—The term ''qualified resident'' means, with respect to a State for a month, an individual who is a resident of the State as of the first day of the month and is a citizen or national of the United States or otherwise lawfully residing in the State under color of law.

(15) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(16) STATE.—The term ''State'' means the 50 States and the District of Columbia.

(17) UNINSURED.—The term ''uninsured'' means, with respect to an individual, that the individual does not have creditable coverage.

Subtitle A—Insurance Reforms

SEC. 101. STATE OPTIONS IN RESPONSE TO BURWELL DECISION.

(a) IN GENERAL.—Each State may elect, through written notice to the Secretary after the date of the enactment of this Act and in accordance with this subtitle, 1 of following 3 options in relation to the implementation of title I of the Patient Protection and Affordable Care Act after the decision of the Supreme Court in King v. Burwell:

(1) CONTINUING IMPLEMENTATION OF PPACA, INCLUDING FEDERAL SUBSIDIES THROUGH A STATE-ESTABLISHED EXCHANGE.—Under current law, the State establishing a health insurance Exchange under title I of PPACA, which thereby permits the continuation of Federal premium and cost-sharing subsidies for coverage offered through the Exchange as well as continuation of insurance and other requirements under such title.

(2) REJECTION OF PPACA, INCLUDING ELIMINATION OF FEDERAL SUBSIDIES NOW PROVIDED THROUGH FEDERALLY ESTABLISHED EXCHANGE.—

Under current law, the State not establishing such an Exchange, potentially resulting, post-Burwell, in the loss of such Federal premium and cost-sharing subsidies and the continued application of other requirements under such title.

(3) ESTABLISHING NEW STATE AND MARKET-BASED ALTERNATIVE, WITH ALTERNATIVE PER CAPITA FEDERAL DEPOSIT SYSTEM.—The State implementing the alternative option described in section 102, which includes—

(A) the waiver of most requirements imposed under such title; and

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

If a State fails to make an election described in this subsection, the State shall be deemed to have made the election described in paragraph (2). A State may, through written notice to the Secretary, change an election previously made under this subsection.

(b) RELATION TO CURRENT MEDICAID ACA COVERAGE OPTION.—Nothing in this section shall be construed to change the option of a State with respect to the implementation of Medicaid ACA coverage under section

1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1395a(a)(10)(A)(i)(VIII)), except that a State that elects not to provide medical assistance to individuals under such section may make such individuals deposit qualifying residents under this title.

SEC. 102. STATE ALTERNATIVE OPTION.

(a) IN GENERAL.—In the case of a State that elects under section 101(a)(3) the alternative option under this section, subject to subsection (d) and section 105, the following shall apply:

(1) NO FEDERAL EXCHANGE.—The Federal Government shall not establish or maintain an Exchange in the State under title I of PPACA.

(2) ELIMINATION OF INDIVIDUAL AND EMPLOYER SHARED RESPONSIBILITY FOR HEALTH CARE TAX REQUIREMENTS FOR RESIDENTS AND EMPLOYEES IN STATE.—The individual and employer health care responsibilities under the amendments made by title I of PPACA (including under sections 5000A and 4980H of the Internal Revenue Code of 1986) shall no longer apply pursuant to section 106 with respect to individuals who are residents of such State and with respect to individuals who are employed in such State, respectively.

(3) MODIFICATION OF INSURANCE REQUIREMENTS.—Except as specifically provided in this title, the requirements under title I of PPACA (including amendments made by such title) relating to health insurance coverage offered in the State shall not apply except to the extent specified by the State.

(4) NEW DEPOSIT SYSTEM THROUGH FUNDING HSAS.—

(A) IN GENERAL.—Deposit qualifying residents (as defined in subsection (b)(2)) who are residing in the State are eligible for a deposit to a health savings account that may be used for premiums and cost-sharing for health insurance coverage in accordance with subsection (b).

(B) STATE SPECIFICATION OF MANNER OF CARRYING OUT HSA DEPOSIT SYSTEM (PATIENT-GRANT ELECTING STATE).—In making the election under this subsection, a State shall specify whether the State will carry out subsection (b) or if such subsection shall be carried out by means of the credit under section 36C of the Internal Revenue Code of 1986.

(5) ADDITIONAL AMOUNTS FOR POPULATION HEALTH INITIATIVES FOR STATE ADMINISTERED

HSA DEPOSIT SYSTEM.—A patient-grant electing State (as defined in section 100(1)) is entitled to receive additional funding under subsection (c) for population health initiatives.

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

(1) IN GENERAL.—The subsidies described in subsection (a)(4) for an electing State shall be furnished for each deposit qualifying resident through the deposit of a contribution into an HSA of the individual in the amount determined under section 103.

(2) DEPOSIT QUALIFYING RESIDENT DEFINED.—In this title, the term ''deposit qualifying resident'' means, with respect to a State and a month, an individual—

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

(B) with respect to whom an HSA has been established, which HSA may have been established by the State in carrying out this section;

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

(D) who is not eligible for coverage under Medicare, is not enrolled for benefits under Medicaid or CHIP, and is not enrolled for benefits under chapter 55 of title 10, United States Code (relating to TRICARE), or title 39 of such Code (relating to veterans' benefits) or chapter 89 of title 5 of such Code (relating to the Federal Employees Health Benefits Program).

(3) PAYMENT ADMINISTRATION.—

(A) STATE.—In the case of an electing State that elects to carry out this subsection through the State, the Secretary shall provide for payment to the State in amounts and in a time and manner sufficient to permit the State to make timely monthly contributions to HSAs under this subsection. The Secretary may provide for payment to the State using the payment methodology described in subsection (d) of section 1903 of the Social Security Act for payments under subsection (a) of such section (ap-

plied without regard to any State matching requirement) and may condition such payments upon the provision of such information as the Secretary may require to ensure the proper payments under this subsection. As a condition of receiving payment under this section, a State shall submit such information, in such form, and manner, as the Secretary shall specify, including information necessary to make the computations of amounts under this section.

(B) FEDERAL.—In the case of a State electing to carry out this subsection other than through the State, subsidies described in subsection (a)(4) shall be provided through a refundable tax credit under section 36C of the Internal Revenue Code of 1986.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed—

(A) to prevent an individual from affirmatively electing not to have an HSA established on the individual's behalf and not to be enrolled under health insurance coverage;

(B) subject to subparagraph (A), to prevent a State from establishing an HSA for each

deposit qualifying resident who does not otherwise have an HSA;

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

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

(c) POPULATION HEALTH INITIATIVE FUNDING.—

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

(2) USE OF FUNDS.—Amounts paid to a State under paragraph (1) may only be used for popu-

lation health initiatives (as defined by the Secretary).

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

(d) REQUIRING RULES FOR COMPUTING USUAL, CUSTOMARY, AND REASONABLE (UCR) PRICES.—As a condition for a State's election of the alternative option under this section, the State must provide, through its department of insurance or equivalent agency, for establishment of rules to carry out section 1867(j)(1)(A)(ii) of the Social Security Act, as added by section 121(a)(2).

SEC. 103. COMPUTATION OF MONTHLY HSA DEPOSIT AMOUNT FOR DEPOSIT QUALIFYING RESIDENTS.

(a) COMPUTATION.—

(1) IN GENERAL.—The Secretary shall develop a standardized methodology to determine consistent with this section a monthly HSA deposit amount for deposit qualifying residents in each State for months in each year. Subject to paragraphs (3) and (4), such amount shall be equal to 1/12 of the average per capita annual amount computed under subsection

(b) for the State for the year, as adjusted for the deposit qualifying resident involved—

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

(B) for income under subsection (d).

(2) NO VARIATION BASED ON HOW DEPOSIT AMOUNT DISTRIBUTED.—Such amount shall be the same for a deposit qualifying individual without regard to whether the contribution to the individual's HSA is made by a State under this section or by the Federal Government through the operation of section 36C of the Internal Revenue Code of 1986.

(3) PATIENT-GRANT ELECTING STATE HAS FLEXIBILITY TO MAINTAIN LEVEL OF BENEFITS FOR CURRENT ACA BENEFICIARIES.—A patient-grant electing State may elect to increase the amount of the deposit for all deposit qualifying individuals under this section to the amounts that the Secretary estimates would have been paid with respect to such individuals under section 36B of the Internal Revenue Code of 1986 and section 1402 of PPACA if those sections had remained in effect in the State with respect to such individuals. Such election shall be made for a year and shall continue from year to year until the State elects to terminate such election.

(4) SPECIAL RULE FOR PARTIAL DEPOSIT FOR LOW-INCOME INDIVIDUALS WITH EMPLOYER-SPONSORED INSURANCE (ESI).—In the case of an individual who is covered under a group health plan and with respect to such coverage there is a contribution by an employer which is excluded from the individual's gross income under the Internal Revenue Code of 1986, insofar as the individual is a deposit qualifying resident, the amount of the deposit with respect to the individual shall be reduced, in a manner specified by the Secretary in consultation with the Secretary of the Treasury and taking into account the income of the individual's household, by an amount that is approximately equivalent to the estimated amount of the reduction in the amount of income tax resulting from such exclusion (and any reduction in taxes imposed by chapter 21 or chapter 2 of such Code by reason of any exclusion of such contributions from wages and self employment income).

(b) COMPUTATION OF UNADJUSTED PER CAPITA.—

(1) FOR STATES THAT CONTINUE PPACA MEDICAID COVERAGE.—

(A) IN GENERAL.—In the case of a State that provides medical assistance under section

1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)(VIII)) during a year, subject to paragraphs (3) and (4), the Secretary shall compute an average per capita annual amount for the State for the year equal to—

(i) the amount specified in subparagraph (B), divided by

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

(B) AMOUNT BASED ON PPACA PROJECTED FEDERAL EXPENDITURES.—The amount specified in this subparagraph for a State for a year is 95 percent of the Secretary's estimate of the total payments that would have been made (assuming the existence of a State established Exchange in the State) under section 36B of the Internal Revenue Code of 1986 and under section 1402 of PPACA with respect to all qualified residents in the State in the year (or taxable year ending with such year, if applicable).

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

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

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

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

(B) AMOUNT BASED ON PPACA AND MEDICAID PROJECTED FEDERAL EXPENDITURES.—The amount specified in this subparagraph for a State for a year is equal to the sum of—

(i) 95 percent of the Secretary's estimate of the total payments that would have been made (assuming the existence of a State-established Exchange in the State) under section 36B of the Internal Revenue Code of 1986 and under section 1402 of PPACA with respect to all qualified residents in the year (or taxable year ending with such year, if applicable); and

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

(3) BUDGET NEUTRAL ADJUSTMENT IN PAYMENTS TO TAKE INTO ACCOUNT ELECTION OF HIGHER DEPOSITS TO MAINTAIN ACA SUBSIDY LEVELS.—If a State makes the election described in subsection (a)(3) with respect to providing higher deposit amounts for certain individuals described in such subsection, then the Secretary shall adjust the average per capita annual amount under paragraph (1) or (2), as applicable to the State, by—

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

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

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

(A) reducing the amount described in paragraph (1)(B) (or, if applicable, paragraph (2)(B)(i)) by an amount equal to 95 percent of the amount of payments under this section that are attributable to individuals described in subsection (a)(4); and

(B) not counting any individual described in subsection (a)(4) as a qualifying resident for purposes of paragraph (1)(A)(ii) (or, if applicable, paragraph (2)(A)(ii)).

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

(1) IN GENERAL.—The Secretary shall apply such adjustments to the per capita amount computed under subsection (b) as is designed to take into account, in a budget neutral manner and based

on the costs estimated under paragraph (2), actuarial differences in health care costs attributable to individuals in different age categories and different geographic locations of primary residences in the State and the reductions based on income under subsection (d). No such adjustment shall be made based on sex.

(2) DATA ON AVERAGE COSTS OF SERVICES.—Not later than December 15 before the beginning of each year, the Agency for Healthcare Research and Quality shall estimate the average cost of health care for such year for individuals under 65 years of age and may estimate how such average varies for different populations of individuals under age 65. The adjustments under paragraph (1) for age categories for a year shall be based on such estimates made. Not later than such date, the Secretary shall prescribe tables for purposes of making adjustments based on age under paragraph (1) based on such determination which shall apply for taxable years beginning in the succeeding calendar year.

(d) INCOME-RELATED PHASE-OUT.—

(1) IN GENERAL.—The per capita amount as computed under subsection (b) and adjusted and applied to a deposit qualifying individual under sub-

section (c) shall be multiplied by a phase-out percentage equal to 100 percent reduced by 1 percentage point for each $1,000 (or fraction thereof) by which the taxpayer's modified adjusted gross income for the taxable year exceeds $90,000 (or, in the case of a joint return, $150,000), multiplied, for a taxable year ending in a year beginning after December 31, 2015, by the cost-of-living adjustment for the year as described in section 1(f)(3) of the Internal Revenue Code of 1986, but substituting ''2015'' for ''1992'' in subparagraph (B) of such section.

(2) ZERO PER CAPITA AMOUNT FOR MARRIED FILING SEPARATELY.—The per capita amount under this section shall be zero in the case of a married couple filing separately.

SEC. 104. STATE OPTIONS FOR IMPROVED ACCESS TO HEALTH INSURANCE COVERAGE IN EACH STATE.

(a) STATE OPTIONS TO IMPROVE ACCESS.—

(1) IN GENERAL.—Each State may carry out any of the functions described in succeeding subsections in order to improve the access of residents of the State to health insurance coverage.

(2) REPURPOSING STATE EXCHANGES.—A State may use or adapt an Exchange that the State

has established under title I of PPACA to carry out the any of such functions.

(3) REPURPOSING FEDERAL EXCHANGE.—The Federal Government shall make available to States current capabilities of the Federal Exchange, including the Federal Data Services Hub and Agent Broker Portal, to the extent requested by a State for activities related to enrollment of citizens of the State into health insurance coverage.

(b) TRANSPARENCY PORTAL.—Each State may establish and operate an open and transparent marketplace mechanism whereby qualified residents of the State can readily compare, through the use of the Internet, the benefits and prices between different health insurance coverage options made available to them.

(c) ENROLLMENT, SUBJECT TO INDIVIDUAL OPT-OUT.—

(1) IN GENERAL.—Subject to paragraph (2), a State may provide for the enrollment of qualified residents of the State who are uninsured in default health insurance coverage offered under section 105(c) and establishing an HSA for such residents who do not have an HSA unless the resident has affirmatively elected not to be so enrolled and not to have an HSA, respectively. Any such enrollment

under this paragraph shall be coordinated with the annual open enrollment periods provided under section 105(b).

(2) SIMPLE PROCESS FOR INDIVIDUALS TO OPT-OUT.—As a condition of a State providing for the enrollment function described in paragraph (1), the State must establish an easy-to-use and transparent means by which individuals may elect not to be enrolled in default health insurance coverage or to have an HSA established on the individual's behalf, or both.

(d) RISK MITIGATION MECHANISMS AND REINSURANCE AND RISK-CORRIDOR PROGRAMS.—

(1) IN GENERAL.—Notwithstanding any other provision of this title or section 223(c)(2) of the Internal Revenue Code of 1986, a State may establish—

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

(B) a reinsurance and risk-corridor program that involves no Federal funds with respect to coverage both in the individual market and in the small group market.

(2) BASIS FOR RISK ADJUSTMENT.—Mechanisms and programs under paragraph (1) may be based on the health status score of each individual enrolled in health insurance coverage in the individual market and not solely based on the aggregate risk of the risk pool with respect to each plan of health insurance coverage.

SEC. 105. EXPANDED ACCESS AND PATIENT PROTECTIONS.

(a) IN GENERAL.—As a condition for the election of the alternative option under section 102 in a State, the State must meet the requirements of this section.

(b) ANNUAL AND OTHER OPEN ENROLLMENT PERIODS.—

(1) IN GENERAL.—The State shall require, in connection with the offering of health insurance coverage in the individual market in the State, that there are uniform annual and other open enrollment periods (such as those for changes in life events, changes in State residency, and involuntary changes in eligibility for coverage under a group health plan) in order to permit qualified residents to enroll in qualified health plan coverage in a manner that promotes continuity of coverage. Such periods shall be consistent with the open enrollment periods estab-

lished under title I of PPACA, as in effect on the day before the date of the enactment of this Act.

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

(c) OFFERING OF DEFAULT HEALTH INSURANCE COVERAGE.—

(1) IN GENERAL.—The State shall provide for the offering, through one or more contracts with one or more health insurance issuers in the State, of default health insurance coverage (as defined in paragraph (2)) to qualified residents of the State who are otherwise uninsured. Such default coverage shall be made available on a continuous basis during a year. Failure of a qualified resident to enroll in such default coverage or other creditable coverage during a year results in adverse consequences described in subsection (d)(1)(B) to the resident.

(2) DEFAULT HEALTH INSURANCE PLAN DEFINED.—In this title, the term ''default health insurance plan'' means, with respect to a State, health insurance coverage that—

(A) is a high deductible health plan (within the meaning of section 223(c)(2) of the Internal Revenue Code of 1986) with prescription drug coverage limited to generic drugs for a limited number of chronic conditions (commonly referred to as tier I pharmacy benefit);

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

(C) has a provider network for covered benefits that is adequate (as determined consistent with guidelines issued by the Secretary) to ensure access to health benefits under such plan;

(D) provides for coverage of childhood immunizations without cost sharing requirements to the extent such immunizations have in effect a recommendation from the Advisory Com-

mittee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

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

(d) CONSEQUENCES RESPECTING CONTINUOUS COVERAGE.—

(1) CONSEQUENCES FOR NOT MAINTAINING CONTINUOUS COVERAGE.—

(A) AVOIDANCE OF CONSEQUENCES BY MAINTAINING CONTINUOUS COVERAGE.—All qualified residents of a State are eligible during the initial open enrollment period provided under subsection (b)(2) to enroll in qualified health plan coverage and, thereafter, to maintain continuous coverage in order to avoid the adverse consequences described in the succeeding provisions of this paragraph.

(B) UNDERWRITING PERMITTED.—In the case of a qualified resident of the State who fails to maintain continuous creditable coverage (not including any breaks in coverage of less than 63 days), the State shall—

(i) permit health insurance issuers for the period specified in subparagraph (C) to

medically underwrite (through denial of health insurance coverage, application of preexisting condition limitations, differential premiums, or otherwise) the issuance of health insurance coverage, other than with respect to the issuance of default health insurance coverage under subsection (c); and

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

(C) PERIOD FOR APPLICATION OF UNDERWRITING.—For purposes of subparagraph (B)(i), the period specified in this subparagraph is, with respect to an uninsured individual as of a date, a period (not to exceed 18 months) equivalent to number of months in the previous 18-month period in which the individual did not

have continuous creditable coverage described in subparagraph (B).

(D) MONTHLY LATE ENROLLMENT PENALTY AMOUNT.—

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

(I) 1 percent of the monthly premium amount for default health insurance coverage with respect to the individual and month; and

(II) the number of months during the 2-year period (preceding the 18-month period described in subparagraph (B)(i)) in which the resident failed to maintain the continuous coverage described in paragraph (1)(D).

(ii) PAYMENT OF PENALTY AMOUNT TO FEDERAL TREASURY.—The amount of the monthly late enrollment penalty collected under this subparagraph shall be paid to the Treasury of the United States in a form and manner specified by the Secretary of the Treasury.

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

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

(B) DURING THIRD AND SUBSEQUENT OPEN ENROLLMENT PERIODS.—In the case of a qualified resident who maintains continuous coverage for a period of 18 months or longer (not including any breaks in coverage of less than 63 days) as of the initial date of a third or subsequent annual open enrollment period

established by the State under subsection (b)(1), the State shall require health insurance issuers to permit such residents during such an open enrollment period to change the qualified health plan coverage in which the individual is enrolled without medical underwriting.

SEC. 106. SUNSETTING CERTAIN ACA PROVISIONS; CONTINUATION OF POLICIES OF COVERING ADULT CHILDREN AND NOT APPLYING LIFETIME OR ANNUAL LIMITS.

(a) IN GENERAL.—Subject to subsections (b) and (c), title I of the Patient Protection and Affordable Care Act (including the amendments made by such title) shall not apply (and the provisions of law amended by such title are restored as if such title had not been enacted) in the case of any State that does not have in effect the election described in section 101(a)(1).

(b) CONTINUATION OF POLICIES FOR EXTENSION OF DEPENDENT COVERAGE FOR ADULT CHILDREN AND PROHIBITION OF LIFETIME AND ANNUAL COVERAGE LIMITS.—Subsection (a) shall not apply with respect to the following:

(1) Section 2711 of the Public Health Service Act (relating to no lifetime or annual limits).

(2) Section 2714 of such Act (relating to extension of dependent coverage).

(c) CONTINUATION OF POLICIES FOR CERTAIN STATES OPERATING EXCHANGES.—Subsection (a) shall not apply with respect to health insurance coverage in a State that has in effect the election described in section 101(a)(1).

Subtitle B—Medicaid

SEC. 111. APPLICATION OF HEALTH SAVINGS ACCOUNTS IN RELATION TO MEDICAID.

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

"SEC. 1947. PROVISIONS RELATING TO HEALTH SAVINGS ACCOUNTS.

''(a) DISREGARDING HSA IN DETERMINING ASSETS AND INCOME FOR MEDICAID ELIGIBILITY DETERMINATIONS OTHER THAN FOR LONG-TERM CARE SERVICES.—The assets in a health savings account under section 223 of the Internal Revenue Code of 1986, and any income from such assets in such account, shall be disregarded for purposes of determining eligibility and amount of medical assistance under this title, other than for purposes of determining eligibility and the amount of medical assistance

for long-term care services (described in section 1917(c)(1)(C)(i)).

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

(b) IMPLEMENTATION OF NOTIFICATION REQUIREMENT THROUGH STATE PLAN.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (77) the following new paragraph:

''(78) provide for notice in accordance with section 1947(b) to the Secretary of the Treasury of the identity of individuals who are determined eligible for (and receiving) medical assistance under this title;''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to eligibility determinations with respect to medical assistance for periods beginning on or after January 1, 2016.

Subtitle C—Provider Price Transparency

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

(a) IN GENERAL.—Section 1867 of the Social Security Act (42 U.S.C. 1395dd) is amended—

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

''(5) ENFORCEMENT WITH RESPECT TO EXCESSIVE CHARGES.—A hospital, physician, or other entity that violates the requirements of subsection (j)(1) with respect to the furnishing of items and services is subject to a civil money penalty of not more than $25,000 for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).''; and

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

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

"(1) IN GENERAL.—If items or services to screen or treat an emergency medical condition are furnished under this section in a participating hospital with respect to an individual and the individual has not, directly or through a health insurance issuer, group health plan, or other third party, negotiated a payment rate for such items and services, subject to paragraph (2), the charges imposed for such items and services may not be in excess of the following:

"(A) PHYSICIANS' AND OTHER PROFESSIONAL SERVICES.—For physicians' services or services of a health care provider to which section 223(e)(9) of the Internal Revenue Code of 1986 applies (and including drugs and biologicals furnished in conjunction with and billed as part of such services), the lesser of—

"(i) the cash price for such services posted pursuant to such section; or

"(ii) 85 percent of the usual, customary, and reasonable (UCR) charge for such services, as determined under rules established by the department of insurance for the State in which the services are furnished.

"(B) HOSPITAL SERVICES.—For inpatient and outpatient hospital services for which payment rates are established under this title (and including drugs and biologicals furnished in conjunction with and billed as part of such services), the lesser of—

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

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

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

"(i) twice the acquisition cost to the hospital or other provider for the dose involved; or

"(ii) the acquisition cost to the hospital or other provider plus $250.

The dollar amount in clause (ii) shall be increased from year to year (beginning with the year after the first year in which this subsection

applies) by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) for the year involved (as determined by the Secretary). Any such dollar amount as so increased that is not a multiple of $5 shall be rounded to the nearest multiple of $5 (or, if a multiple of $2.50, to the next highest multiple of $5).

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

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

''(ii) 110 percent of the payment basis that would be applicable to payment for such items and services under this title in the case of an individual entitled to benefits under part A and enrolled under part B.

''(2) SPECIAL RULE FOR ITEMS AND SERVICES FURNISHED AS A BUNDLE.—In the case of items and services for which there is a single price for a group or bundle of such items and services, the max-

imum charge permitted under paragraph (1) may not exceed the lesser of—

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

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

(b) REFERENCE TO PRICE DISCLOSURE PROVISION.—For requirements relating to the posting of health care prices on the Internet, see section 223(e)(9) of the Internal Revenue Code of 1986, as added by section 204(a).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to charges imposed for items and services furnished on or after January 1, 2016.

TITLE II—REFORM OF TAX PROVISIONS RELATING TO HEALTH CARE

Subtitle A—Promotion of Health Savings Accounts

SEC. 201. REPEAL OF HIGH DEDUCTIBLE HEALTH PLAN REQUIREMENT.

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

''(a) DEDUCTION ALLOWED.—In the case of an individual, there shall be allowed as a deduction for a taxable year an amount equal to the aggregate amount paid in cash during such taxable year by or on behalf of such individual to a health savings account of such individual.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 223(b)(1) of such Code is amended by striking ''that the individual is an eligible individual''.

(2) Section 223(b)(2) of such Code is amended by striking ''under a high deductible health plan'' each place it appears.

(3) Section 223(b) of such Code is amended by striking paragraph (8).

(4) Section 223 of such Code is amended by striking subsection (c) and redesignating subsections (d) through (h) as subsections (c) through (g), respectively.

(5) Section 223(c)(1)(A) of such Code, as redesignated by this Act, is amended by striking ''subsection (f)(5)'' and inserting ''subsection (e)(5)''.

(6) Section 223(f)(1) of such Code, as redesignated by this Act, is amended—

(A) by striking ''subsections (b)(2) and (c)(2)(A)'' and inserting ''subsection (b)(2)'',

(B) by striking ''subparagraph (B) thereof—'' and all that follows through the end of subparagraph (B) and inserting ''subparagraph (B) thereof 'calendar year 1997'.'', and

(C) by striking ''amounts under subsections (b)(2) and (c)(2)(A)'' in the second sentence and inserting ''amounts under subsection (b)(2)''.

(7) Section 26(b)(2)(U) of such Code is amended by striking ''section 223(f)(4)'' and inserting ''section 223(e)(4)''.

(8) Sections 35(g)(3), 220(f)(5)(A), 848(e)(1)(B)(v), 4973(a)(5), and 6051(a)(12) of such Code are each amended by striking ''section 223(d)'' each place it appears and inserting ''section 223(c)''.

(9) Section 106(d)(1) of such Code is amended—

(A) by striking ''who is an eligible individual (as defined in section 223(c)(1))'', and

(B) by striking ''section 223(d)'' and inserting ''section 223(c)''.

(10) Section 408(d)(9) of such Code is amended—

(A) in subparagraph (A) by striking ''who is an eligible individual (as defined in section 223(c)) and'', and

(B) in subparagraph (C) by striking ''computed on the basis of the type of coverage under the high deductible health plan covering the individual at the time of the qualified HSA funding distribution''.

(11) Section 877A(g)(6) of such Code is amended by striking ''223(f)(4)'' and inserting ''223(e)(4)''.

(12) Section 4973(g) of such Code is amended—

(A) by striking ''section 223(d)'' and inserting ''section 223(c)'',

(B) by striking ''223(f)(5)'' in paragraph (1) and inserting ''223(e)(5)'',

(C) by striking ''section 223(f)(2)'' in paragraph (2) and inserting ''section 223(e)(2)'', and

(D) by striking ''section 223(f)(3)'' in the second sentence and inserting ''section 223(e)(3)''.

(13) Section 4975 of such Code is amended—

(A) in subsection (c)(6)—

(i) by striking ''section 223(d)'' and inserting ''section 223(c)'', and

(ii) by striking ''section 223(e)(2)'' and inserting ''section 223(d)(2)'', and

(B) in subsection (e)(1)(E), by striking ''section 223(d)'' and inserting ''section 223(c)''.

(14) Section 6693(a)(2)(C) of such Code is amended by striking ''section 223(h)'' and inserting ''section 223(g)''.

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

SEC. 202. TREATMENT OF HSA AFTER DEATH OF ACCOUNT BENEFICIARY.

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

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

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

SEC. 203. PURCHASE OF HEALTH INSURANCE FROM HSA ACCOUNT.

(a) IN GENERAL.—Section 223(c)(2) of the Internal Revenue Code of 1986, as redesignated by section 201(c)(3), is amended—

(1) in subparagraph (C)—

(A) by striking ''or'' at the end of clause (iii),

(B) by striking the period at the end of clause (iv) and inserting '', and'', and

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

''(v) in the case of health insurance that meets the requirements of subparagraph (D).''; and

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

''(D) REQUIREMENTS.—The requirements of this subparagraph are as follows:

''(i) OPEN ENROLLMENT WITHOUT PREEXISTING CONDITION EXCLUSIONS.—The health insurance coverage or group

health plan must permit, during uniform initial and annual open enrollment periods and for special enrollment periods (such as the loss of coverage through the loss of employment) specified in carrying out section 105(b) of the Patient Freedom Act of 2015, any individual who has period of continuous coverage of not less than 18 months who is otherwise eligible to enroll under such coverage or plan to be so enrolled without the imposition of any preexisting condition exclusion (as defined for purposes of title XXVII of the Public Health Service Act).

''(ii) CLASS BASED PREMIUMS FOR BASIC BENEFITS.—

''(I) IN GENERAL.—The premium for such coverage or plan shall be established based on class-average status and may vary by age and geographic area, but may not vary based upon the health status of the individual, except that in the case of an individual without continuous coverage for a period of 42 months, such

premium may be increased above the class-average in the manner and for the time period specified in section 105(d)(1)(A)(ii) of the Patient Freedom Act of 2015.

"(II) ESTABLISHMENT OF ACTUARIAL TABLES.—In carrying out subclause (I), the Secretary shall enter into a contract with a qualified organization, such as the Academy of Actuaries, for the development of actuarial tables to calculate class-average rates based on age and geography.

"(E) CONTINUOUS COVERAGE.—For purposes of this paragraph, an individual shall be considered to have continuous coverage as of a time if the individual has no continuous period in which the individual is uninsured (as defined in section 100 of the Patient Freedom Act of 2015) for longer than 63 days beginning after the date of the enactment of such Act.".

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

SEC. 204. PUBLISHING OF CASH PRICE FOR CARE PAID THROUGH HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 223(e) of the Internal Revenue Code of 1986, as redesignated by section 201(c)(3), is amended by adding at the end the following new paragraph:

''(9) CASH PRICE TRANSPARENCY REQUIRED FOR PAYMENTS TO HEALTH CARE PROVIDERS.—

''(A) IN GENERAL.—A payment to a health care provider with respect to the furnishing of health care items and services by such provider shall not be treated as a qualified medical expense unless health care provider provides for continuing disclosure (such as through posting on a publicly accessible website) of the cash price the health care provider charges for the furnishing of such items and services.

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

''(i) to establish a single price for related items and services in a manner similar to the manner in which pricing and payment for such items and services is pro-

vided under the Medicare program under title XVIII of the Social Security Act, and

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

''(C) FAILURE TO FURNISH SERVICES OR CHARGE IN EXCESS OF STATED PRICE.—A health care provider shall be treated as not meeting the requirement of subparagraph (A), in the case of items and services for which the provider is disclosing a cash price, if the provider—

''(i) refuses to furnish such items or services at the price listed, or

''(ii) charges more than the price listed for the furnishing of the items and services.''.

(b) ENFORCEMENT.—If the Secretary of Health and Human Services determines that a health care provider has not provided for continuing disclosure of the cash price of health care provider charges under section 223(e)(9) of the Internal Revenue Code of 1986, the Secretary may instruct the Secretary of the Treasury that payments made to such provider shall be not treated, for purposes of section 223 of the Internal Revenue Code of

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

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

Subtitle B—Health Care Tax Credits

SEC. 211. LIMITED APPLICATION OF PPACA HEALTH PREMIUM CREDIT.

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

"(E) SPECIAL RULE FOR RESIDENTS OF STATES CONTINUING PPACA IMPLEMENTATION.—No credit shall be allowed under this section to any individual who is not a qualified resident (as defined in section 100(14) of the Patient Freedom Act of 2015) of a State that has elected the option under section 101(a)(1) of such Act in relation to the implementation of title I of the Patient Protection and Affordable Care Act.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2015.

SEC. 212. NEW HSA CREDIT.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 36B the following new section:

"SEC. 36C. HSA CREDIT.

"(a) IN GENERAL.—In the case of a qualifying individual, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year, an amount equal to the HSA credit amount of the individual for the taxable year.

"(b) QUALIFYING INDIVIDUAL.—For purposes of this section, the term 'qualifying individual' means, with respect to any month, any individual who for such month is a deposit qualifying resident (as defined in section 102(b)(2) of the Patient Freedom Act of 2015) of a State described in section 101(a)(3) of such Act that elects to have section 102(b) of such Act carried out by way of the credit determined under this section.

"(c) HSA CREDIT AMOUNT.—For purposes of this section, the term 'HSA credit amount' means, with respect to any taxable year, the sum of the HSA deposit amounts determined under section 103 of the Patient Freedom Act of 2015 with respect to the individual for all months ending during the taxable year.

''(d) SPECIAL RULES.—For purposes of this section—

''(1) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—

''(A) EXCESS ADVANCE PAYMENTS.—If the advance payments to an individual for a taxable year under subsection (e) exceed the credit allowed by this section with respect to such individual for such taxable year, the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

''(B) ADVANCE PAYMENT SHORTFALL.—If the credit allowed by this section (determined without regard to this subparagraph) with respect to an individual for a taxable year exceeds the advance payments to such individual for such taxable year under subsection (e), the Secretary shall, in lieu of a credit allowed against the tax imposed by this subtitle, make a payment on behalf of such individual to such individual's health savings account in an amount equal to such excess.

''(2) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year,

the credit shall be allowed under this section only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

''(e) ADVANCE PAYMENT PROGRAM.—

''(1) IN GENERAL.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall establish a program—

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

''(B) to make advance payments of the credit allowed under this section directly to the health savings account of any such individual so eligible.

''(2) PROGRAM REQUIREMENTS.—Such program shall be established under rules similar to the rules of section 1412 of the Patient Protection and Affordable Care Act, except that advance determinations and advance payments shall be made on request of the individual with respect to whom the determination is to be made and taking into account the enrollment process (including any opt-out election under such process) established under section 104(c)(1) of the Patient Freedom Act of 2015.''.

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

"Sec. 36C. HSA credit.".

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

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