

114TH CONGRESS  
2D SESSION

# S. 2985

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 SENATE OF THE UNITED STATES

MAY 25, 2016

Mr. CASSIDY introduced the following bill; which was read twice and referred to the Committee on Finance

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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,*

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

5 (a) SHORT TITLE.—This Act may be cited as the  
6 “World’s Greatest Healthcare Plan Act of 2016”.

1 (b) PURPOSES.—The purposes of this Act are as fol-  
 2 lows:

3 (1) ELIMINATION OF INDIVIDUAL AND EM-  
 4 PLOYER MANDATES UNDER ACA.—To eliminate man-  
 5 dates on individuals and employers, and other tax  
 6 requirements, imposed under Patient Protection and  
 7 Affordable Care Act.

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

18 (c) TABLE OF CONTENTS.—The table of contents of  
 19 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—Universal Health Insurance Tax Benefit

Sec. 131. Universal 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 direct primary care.

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” has the meaning given such  
5 term in section 122(a).

6 (2) DEFAULT HEALTH INSURANCE COV-  
7 ERAGE.—The term “default health insurance cov-  
8 erage” has the meaning given such term in section  
9 121(b)(4)(B).

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

3           (4) HEALTH INSURANCE COVERAGE; GROUP  
4           HEALTH PLAN, ETC.—The terms defined in section  
5           2791 of the Public Health Service Act, including  
6           “health insurance coverage”, “group health plan”  
7           “individual market”, shall apply.

8           (5) LIMITED BENEFIT INSURANCE.—The term  
9           “limited benefit insurance” has the meaning given  
10          such term in section 122(b).

11          (6) PPACA.—The term “PPACA” means the  
12          Patient Protection and Affordable Care Act (Public  
13          Law 111–148).

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

16          (8) STATE.—The term “State” includes the  
17          District of Columbia, Puerto Rico, the United States  
18          Virgin Islands, American Samoa, Guam, and the  
19          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 Act of 2016.”.

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 (GG), by striking subparagraph (HH), and by redes-  
11 ignating subparagraph (II) as subparagraph (HH).

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

15           (d) EFFECTIVE DATES.—

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

21                   (2) REPEAL OF STUDY AND REPORT.—The  
22 amendment made by subsection (c)(3) shall take ef-  
23 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 or other  
 7 employment plans, under which an employer reimburses  
 8 an employee for the premiums for the purchase of indi-  
 9 vidual health insurance coverage does not constitute a  
 10 group health plan for any purposes, including for purposes  
 11 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 (Public Law 111-148).

17 (3) The Internal Revenue Code of 1986.

18 (4) The Employee Retirement Income Security  
 19 Act of 1974 (29 U.S.C. 1001 et seq.).

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 (Public Law 104-191).

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 part 6 of subtitle B of title  
 3 I of the Employee Retirement Income Security Act  
 4 of 1974 (29 U.S.C. 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 before the date of the en-  
 19 actment of PPACA shall apply instead of the provi-  
 20 sions of such title as in effect after such date.

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



1 health insurance coverage offered in the individual  
2 and group market:

3 (A) NO LIFETIME OR ANNUAL LIMITS.—  
4 Section 2711 (relating to no lifetime or annual  
5 limits), except in the case of limited benefit in-  
6 surance (as defined in section 122(b)).

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

10 (C) MODIFIED GUARANTEED AVAIL-  
11 ABILITY.—Section 2702 (relating to guaranteed  
12 availability of coverage), subject to paragraph  
13 (3) and subsection (c).

14 (D) GUARANTEED RENEWABILITY.—Sec-  
15 tion 2703 (relating to guaranteed renewability  
16 of coverage).

17 (E) PROHIBITING PRE-EXISTING CONDI-  
18 TION EXCLUSIONS.—Section 2704 (relating to  
19 prohibition on preexisting conditions).

20 (F) PROHIBITING DISCRIMINATION BASED  
21 ON HEALTH STATUS.—Section 2705 (relating to  
22 prohibiting discrimination against individual  
23 participants and beneficiaries based on health  
24 status), subject to subsection (c).

1 (G) NON-DISCRIMINATION IN HEALTH  
2 CARE.—Section 2706 (relating to non-discrimi-  
3 nation in health care).

4 (3) APPLICATION OF A LATE ENROLLMENT  
5 PENALTY FOR THOSE WITHOUT CONTINUOUS COV-  
6 ERAGE.—

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

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

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

15 (A) IN GENERAL.—In applying this sub-  
16 section, the provisions described in paragraph  
17 (2) shall be treated as if they were included in  
18 title XXVII of the Public Health Service Act,  
19 as in effect on the day before the date of enact-  
20 ment of PPACA, and, with respect to group  
21 health plans and health insurance coverage of-  
22 fered in connection with such plans, in part 7  
23 of subtitle B of title I of the Employee Retirement  
24 and Income Security Act of 1974 (29  
25 U.S.C. 181 et seq.), and, with respect to group

health plans, in chapter 100 of the Internal Revenue Code of 1986 as follows:

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

(I) with respect to group health plans (and health insurance coverage offered with respect to such plans), under subpart 2 of part A of title XXVII of the Public Health Service Act and subpart B of part 7 of subtitle B of title I of the Employee Retirement and Income Security Act of 1974;

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

(III) with respect to individual health insurance coverage, under subpart 2 of part B of title XXVII of the Public Health Service Act.

(ii) REMAINING PROVISIONS.—The provision described in paragraph (2) (other

than in subparagraph (A) or (B) of such paragraph) shall be treated as included—

(I) with respect to group health plans (and health insurance coverage offered with respect to such plans), under subpart 1 of part A of title XXVII of the Public Health Service Act and subpart A of part 7 of subtitle B of title I of the Employee Retirement and Income Security Act of 1974;

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

(III) with respect to individual health insurance coverage, under subpart 1 of part B of title XXVII of the Public Health Service Act.

(B) **CONFLICTING PROVISIONS.**—In the case described in paragraph (1) where there is a conflict between a provision described in paragraph (2) and a provision of law described in paragraph (1), the provision described in paragraph (2) shall control and the Secretary, in

1 consultation with the Secretary of the Treasury  
2 and the Secretary of Labor, shall establish such  
3 rules as may be necessary to carry out this sub-  
4 paragraph.

5 (5) CONFORMING AMENDMENTS.—

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

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

12 (ii) by adding at the end the following  
13 new subsection:

14 “(c) ADDITIONAL EXCEPTION.—Pursuant to section  
15 121 of the World’s Greatest Healthcare Plan Act of 2016,  
16 the provisions of part A of title XXVII of the Public  
17 Health Service Act referred to in subsection (a), other  
18 than those provisions specified in section 121(a)(2) of the  
19 World’s Greatest Healthcare Plan Act of 2016, shall not  
20 apply to plans and coverage described in subsection (a),  
21 whether or not the plans or coverage are offered through  
22 an Exchange established under the Patient Protection and  
23 Affordable Care Act.”.

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

1 (i) in subsection (a), by striking “sub-  
 2 section (b)” and inserting “subsections (b)  
 3 and (c)”; and

4 (ii) by adding at the end the following  
 5 new subsection:

6 “(c) ADDITIONAL EXCEPTION.—Pursuant to section  
 7 121 of the World’s Greatest Healthcare Plan Act of 2016,  
 8 the provisions of part A of title XXVII of the Public  
 9 Health Service Act referred to in subsection (a), other  
 10 than those provisions specified in section 121(a)(2) of the  
 11 World’s Greatest Healthcare Plan Act of 2016, shall not  
 12 apply to plans described in subsection (a).”.

13 (b) STATE FLEXIBILITY IN ENSURING ORDERLY  
 14 HEALTH INSURANCE MARKET OUTSIDE OF AN EX-  
 15 CHANGE.—

16 (1) IN GENERAL.—With respect to health insur-  
 17 ance coverage offered in a State, the State may, in  
 18 consultation with the Secretary, take such steps,  
 19 such as limiting the availability of general open en-  
 20 rollment periods, imposing delays in the effectiveness  
 21 for coverage, permitting differentials in premiums  
 22 based on age and other factors, as the State deter-  
 23 mines necessary in order to ensure an orderly mar-  
 24 ket for health insurance coverage in the State that  
 25 is not offered through an Exchange. Such steps may

1 include the establishment of such initial open enroll-  
 2 ment period during which qualified residents may  
 3 enroll in health insurance coverage without the im-  
 4 position of any underwriting as the State determines  
 5 to be appropriate in ensuring initial access to such  
 6 coverage.

7 (2) FLEXIBILITY IN IMPOSING ADDITIONAL RE-  
 8 QUIREMENTS.—Nothing in this section shall be con-  
 9 strued as preventing a State from continuing to  
 10 apply, to health insurance coverage issued in the  
 11 State, requirements under the provisions of title  
 12 XXVII of the Public Health Service Act (as amend-  
 13 ed by subtitles A and C of title I of PPACA) that  
 14 are not continued under subsection (a).

15 (3) STATE FLEXIBILITY WITH RESPECT TO EX-  
 16 CHANGES.—A State may waive such provisions of  
 17 part 2 of subtitle D of title I of PPACA, in relation  
 18 to the establishment of an Exchange in such State,  
 19 as the State determines appropriate in order for the  
 20 State to implement and administer a market-based  
 21 system for the availability of health insurance cov-  
 22 erage throughout the State.

23 (4) STATE DEFAULT ENROLLMENT OPTION.—

24 (A) ENROLLMENT, SUBJECT TO INDIV-  
 25 VIDUAL OPT-OUT.—Subject to subparagraph



(D), a State may elect to provide for the enrollment of residents of the State who are uninsured in default health insurance coverage (as defined in subparagraph (B)) and establishing a Roth HSA for such residents who do not have a Roth HSA unless the resident has affirmatively elected not to be so enrolled and not to have such an account. respectively. If a State makes such an election, the State shall permit eligible residents to enroll in such coverage on a continuous basis.

(B) DEFAULT HEALTH INSURANCE COVERAGE DEFINED.—In this paragraph, the term “default health insurance coverage” means, with respect to a State, health insurance coverage that—

(i) 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);

(ii) meets such requirements as may apply to qualify for the payment of plan

1 premiums from a health savings account  
 2 under section 223 of such Code (such as  
 3 age-related premiums and limitation on  
 4 imposition of preexisting condition exclu-  
 5 sions);

6 (iii) has a provider network for cov-  
 7 ered benefits that is adequate (as deter-  
 8 mined consistent with guidelines issued by  
 9 the Secretary) to ensure access to health  
 10 benefits under such plan;

11 (iv) provides for coverage of childhood  
 12 immunizations without cost sharing re-  
 13 quirements to the extent such immuniza-  
 14 tions have in effect a recommendation  
 15 from the Advisory Committee on Immuni-  
 16 zation Practices of the Centers for Disease  
 17 Control and Prevention with respect to the  
 18 individual involved; and

19 (v) meets such other requirements as  
 20 the State may specify.

21 (C) ROTH HSA.—In this paragraph, the  
 22 term “Roth HSA” shall have the meaning given  
 23 such term by section 530A(c) of the Internal  
 24 Revenue Code of 1986.

1 (D) SIMPLE PROCESS FOR INDIVIDUALS TO  
 2 OPT-OUT.—As a condition of a State providing  
 3 for the enrollment function described in sub-  
 4 paragraph (A), the State shall establish an  
 5 easy-to-use and transparent means by which in-  
 6 dividuals may elect not to be enrolled in default  
 7 health insurance coverage or to have a Roth  
 8 HSA established on the individual’s behalf, or  
 9 both.

10 (c) INAPPLICABILITY OF REQUIRED ESSENTIAL  
 11 HEALTH BENEFITS.—

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

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

23 (d) EFFECTIVE DATE; TRANSITION.—

1           (1) IN GENERAL.—Subsections (a), (b), and (c)  
 2           shall apply to plan years beginning after the date of  
 3           the enactment of this Act.

4           (2) SUNSETTING REQUIRED CONTRIBUTION FOR  
 5           ACA REINSURANCE PROGRAM.—No contribution shall  
 6           be required under section 1341 of PPACA (42  
 7           U.S.C. 18061) from any group health plan or health  
 8           insurance issuer for portions of plans years occur-  
 9           ring in months beginning more than 30 days after  
 10          the date of the enactment of this Act.

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

16          (f) TRANSFERRING HEALTH PLAN RECORDS UPON  
 17          CHANGING PLANS.—

18               (1) IN GENERAL.—In the case of an individual  
 19               who is covered under health insurance coverage or as  
 20               a beneficiary or participant in a group health plan  
 21               (as such terms are defined in section 2791 of the  
 22               Public Health Service Act), if such coverage is ended  
 23               and the individual obtains other health insurance  
 24               coverage, group health plan coverage, or other cred-  
 25               itable coverage (as defined for purposes of title

1 XXVII of such Act), the issuer of the prior coverage  
 2 or administrator of the prior plan shall forward in-  
 3 formation respecting such prior coverage to the  
 4 issuer of the new coverage or administrator of the  
 5 new plan or coverage, as the case may be, subject  
 6 to such rules as the Secretary establishes regarding  
 7 the right of the beneficiary or participant to object  
 8 to such forwarding of information.

9 (2) TREATMENT AS PLAN REQUIREMENT  
 10 UNDER PHSA, ERISA, IRC.—The requirement of  
 11 paragraph (1) shall apply as if it were included in  
 12 part A of title XXVII of the Public Health Service  
 13 Act, including for purposes of applying section 715  
 14 of the Employee Retirement Income Security Act of  
 15 1976 (29 U.S.C. 1185d) and section 9815 of the In-  
 16 ternal Revenue Code of 1986.

17 (g) APPLICATION OF RISK ADJUSTMENT.—

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

1           (2) FORM AND DESIGN OF RISK ADJUSTMENT  
2           MECHANISM.—The Secretary shall, in consultation  
3           with the National Association of Insurance Commis-  
4           sioners and other interested parties, develop a mech-  
5           anism to permit the adjustment of risk among  
6           health insurance coverage offered in the individual  
7           market throughout the 50 States and the District of  
8           Columbia. Such mechanism shall be designed to ef-  
9           fect the same type of risk adjustment among such  
10          coverage that is applicable to risk adjustment of  
11          payments among Medicare Advantage organizations  
12          under part C of title XVIII of the Social Security  
13          Act (42 U.S.C. 1395w–21 et seq.).

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

19          (4) DEVELOPMENT OF FURTHER RISK ADJUST-  
20          MENT MECHANISM.—The Secretary shall request the  
21          National Association of Insurance Commissioners to  
22          develop a permanent model for adjustment of risk  
23          among health insurance issuers with respect to  
24          health insurance coverage offered in the individual  
25          market, with the intention that such a model would

1 substitute for the mechanism developed under para-  
 2 graph (2).

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

11 **SEC. 122. OFFERING OF BASIC HEALTH INSURANCE; PRO-**  
 12 **TECTION OF ASSETS FROM LIABILITY OR AT-**  
 13 **TACHMENT OR SEIZURE.**

14 (a) REQUIREMENT FOR EXCHANGES.—

15 (1) IN GENERAL.—No tax credit shall be allow-  
 16 able under section 36B or 36C of the Internal Rev-  
 17 enue Code of 1986 for residents of a State unless  
 18 any Exchange established in the State provides for  
 19 the offering of basic health insurance in all areas of  
 20 the State.

21 (2) BASIC HEALTH INSURANCE DEFINED.—In  
 22 this subsection, the term “basic health insurance”  
 23 means, with respect to a State, such health insur-  
 24 ance coverage as the State may specify and includes

1 limited benefit insurance (as defined in subsection  
2 (b)).

3 (b) LIMITED BENEFIT INSURANCE DEFINED.—

4 (1) IN GENERAL.—In this section, the term  
5 “limited benefit insurance” means individual health  
6 insurance coverage that, with respect to a plan year,  
7 imposes (consistent with paragraph (2)) an annual  
8 limit on the amounts that may be payable under the  
9 coverage with respect to expenses incurred for items  
10 and services furnished in that plan year.

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

19 (c) PROTECTION OF CERTAIN ASSETS IN CASE OF  
20 INDIVIDUALS COVERED UNDER LIMITED BENEFIT IN-  
21 SURANCE.—

22 (1) IN GENERAL.—Notwithstanding any other  
23 provision of law, if an individual is covered under  
24 limited benefit insurance for a plan year and bene-  
25 fits under such insurance have reached the annual



1 limit under such insurance for items and services  
 2 furnished in the plan year, the individual is not lia-  
 3 ble for debt incurred and arising from the provision  
 4 of subsequently furnished items and services during  
 5 the plan year, regardless of whether benefits are oth-  
 6 erwise covered for such items and services under  
 7 such policy, insofar as the liability attributable to  
 8 such items and services exceeds—

9 (A) the bankruptcy valuation of the indi-  
 10 vidual's property at the time the debt is in-  
 11 curred; reduced by

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

14 Property in the amount so protected from liability  
 15 shall be exempt and immune from attachment or sei-  
 16 zure with respect to any judgment related to such  
 17 debt.

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

1           (3) NO REQUIREMENT FOR PROVIDERS TO FUR-  
 2           NISH SUBSEQUENT SERVICES WITHOUT ENSURING  
 3           PAYMENT.—Except as may be explicitly provided in  
 4           other law (such as under section 1867 of the Social  
 5           Security Act (42 U.S.C. 1395dd), popularly known  
 6           as EMTALA), a health care provider is not required  
 7           to furnish any items or services to an individual who  
 8           has exhausted benefits under limited benefit insur-  
 9           ance for a plan year without the individual (or an-  
 10          other person on the individual’s behalf) providing for  
 11          such advance or guarantee of payment for such  
 12          items and services as may be arranged between the  
 13          health care provider and the individual.

14           **Subtitle C—Universal Health**  
 15           **Insurance Tax Benefit**

16   **SEC. 131. UNIVERSAL HEALTH INSURANCE TAX BENEFIT.**

17          (a) IN GENERAL.—Subpart C of part IV of sub-  
 18          chapter A of chapter 1 of the Internal Revenue Code of  
 19          1986 is amended by inserting after section 36B the fol-  
 20          lowing new section:

21   **“SEC. 36C. UNIVERSAL HEALTH INSURANCE TAX CREDIT.**

22          “(a) IN GENERAL.—In the case of a taxpayer who  
 23          is a qualified resident, there shall be allowed as a credit  
 24          against the tax imposed by this subtitle for any taxable

1 year an amount equal to the universal health credit  
2 amount of the taxpayer for the taxable year.

3 “(b) UNIVERSAL HEALTH CREDIT AMOUNT.—For  
4 purposes of this section—

5 “(1) IN GENERAL.—The term ‘universal health  
6 credit amount’ means the sum of the amounts deter-  
7 mined under paragraph (2) with respect to all  
8 months of the taxpayer for the taxable year.

9 “(2) MONTHLY CREDIT AMOUNT.—

10 “(A) IN GENERAL.—Subject to paragraph  
11 (3), the amount determined under this para-  
12 graph with respect to any month shall be an  
13 amount equal to the sum of—

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

21 “(ii)  $\frac{1}{12}$  of an amount equal to  
22 \$1,500 multiplied by the number of quali-  
23 fying children (within the meaning of sec-  
24 tion 152(c)) who are qualified residents  
25 and—

1 “(I) for whom the taxpayer is al-  
 2 lowed a deduction under section 151  
 3 for the taxable year in which such  
 4 month ends, and

5 “(II) who are covered by cred-  
 6 itable coverage on the first day of  
 7 such month.

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

20 “(3) MONTHLY LIMITATION.—

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

1 “(i) the amounts contributed to a  
 2 health savings account of the taxpayer for  
 3 such month, plus

4 “(ii) the premiums paid by the tax-  
 5 payer for creditable coverage.

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

18 “(4) ADJUSTMENT FOR LIMITED BENEFIT IN-  
 19 SURANCE.—In the case of a taxpayer whose only  
 20 health insurance coverage for a month is limited  
 21 benefit insurance (as defined in section 122(b) of the  
 22 World’s Greatest Healthcare Plan Act of 2016), the  
 23 amount determined under paragraph (2) shall be de-  
 24 creased by such proportion as the Secretary, in con-  
 25 sultation with the Secretary of Health and Human

1 Services, determines appropriate, taking into ac-  
 2 count the ratio of the actuarial value of such limited  
 3 benefit insurance to the average actuarial value of  
 4 health insurance coverage that is not limited benefit  
 5 insurance.

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

22 “(c) COORDINATION WITH EMPLOYER-PROVIDED  
 23 HEALTH INSURANCE TAX SUBSIDY.—

24 “(1) CREDIT LIMITED BY EMPLOYER-PROVIDED  
 25 HEALTH INSURANCE TAX SUBSIDY.—The credit al-

lowed under this section for any taxable year shall not exceed an amount equal to the excess (if any) of—

“(A) the maximum credit which would be allowed for all months of the taxpayer during the taxable year (determined under subsection (b)(2) and without regard to this subsection, the limitation under subsection (b)(3), and any reduction under subsection (d)(1)), over

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

“(2) RECAPTURE OF EXCESS EMPLOYER-PROVIDED HEALTH INSURANCE TAX SUBSIDY.—In the case of a taxpayer for whom the amount described in subparagraph (B) of paragraph (1) exceeds the amount described in subparagraph (A) of such paragraph for any taxable year, the credit allowed under this section shall be treated as zero and the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

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

“(A) IN GENERAL.—The term ‘employer-provided health insurance tax subsidy’ means,

1 with respect to any taxpayer for a taxable year,  
 2 the sum of—

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

5 “(ii) the Federal payroll tax subsidy  
 6 of the taxpayer for the taxable year.

7 “(B) FEDERAL INCOME TAX SUBSIDY.—

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

11 “(i) the amount of tax that would  
 12 have been imposed by this chapter for the  
 13 taxable year had such tax been determined  
 14 without regard to this section and by in-  
 15 cluding amounts otherwise excluded from  
 16 gross income which were paid by or on be-  
 17 half of the taxpayer for employer-provided  
 18 insurance that constitutes medical care,  
 19 over

20 “(ii) the amount of tax imposed by  
 21 this chapter for the taxable year (deter-  
 22 mined without regard to this section).

23 “(C) FEDERAL PAYROLL TAX SUBSIDY.—

24 The term ‘Federal payroll tax subsidy’ means,



1 with respect to any taxpayer for the taxable  
2 year, the excess (if any) of—

3 “(i) the sum of—

4 “(I) the amount of tax that  
5 would have been imposed by chapter  
6 21 with respect to any wages of the  
7 taxpayer paid during the taxable year  
8 had such tax been determined by in-  
9 cluding amounts otherwise excluded  
10 from wages which were paid by or on  
11 behalf of the taxpayer during the tax-  
12 able year for employer-provided insur-  
13 ance that constitutes medical care,  
14 plus

15 “(II) the amount of tax that  
16 would have been imposed by chapter 2  
17 on any self-employment income of the  
18 taxpayer for such taxable year had  
19 self-employment income been deter-  
20 mined without regard to any deduc-  
21 tion from gross income for amounts  
22 paid for insurance which constitutes  
23 medical care for the taxpayer, the tax-  
24 payer’s spouse, and any qualifying  
25 children (within the meaning of sec-

1                   tion 152) for whom the taxpayer is al-  
 2                   lowed a deduction under section 151  
 3                   for the taxable year, over

4                   “(ii) the amount of tax imposed with  
 5                   respect to the taxpayer during such taxable  
 6                   year under chapter 21 and for such taxable  
 7                   year under chapter 2.

8                   “(4) NO CREDIT OR RECAPTURE FOR INSUR-  
 9                   ANCE PROVIDED BY EMPLOYER ELECTING EXCLU-  
 10                  SION REGIME.—In the case of an individual who for  
 11                  any month is covered by insurance that constitutes  
 12                  medical care and that is provided by an employer  
 13                  with respect to which an election is in effect for such  
 14                  month under section 131(b) of the World’s Greatest  
 15                  Healthcare Plan Act of 2016—

16                  “(A) the monthly credit amount deter-  
 17                  mined under subsection (b)(2) for such month  
 18                  with respect to such individual shall be zero,  
 19                  and

20                  “(B) such month shall not be taken into  
 21                  account for purposes of determining any recap-  
 22                  ture under paragraph (2) with respect to such  
 23                  individual.

24                  “(d) RECONCILIATION OF CREDIT AND ADVANCE  
 25                  CREDIT.—

1           “(1) IN GENERAL.—The amount of the credit  
2           allowed under this section for any taxable year (after  
3           the application of subsections (b) and (c)) shall be  
4           reduced (but not below zero) by the amount of any  
5           advance payment of such credit under subsection  
6           (e)(1).

7           “(2) EXCESS ADVANCE PAYMENTS.—

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

15                  “(B) LIMITATION ON INCREASE.—In the  
16                  case of a taxpayer whose household income is  
17                  less than 400 percent of the poverty line for the  
18                  size of the family involved for the taxable year,  
19                  the amount of the increase under subparagraph  
20                  (A) shall not exceed the applicable dollar  
21                  amount determined in accordance with the fol-  
22                  lowing table (one-half of such amount in the  
23                  case of a taxpayer whose tax is determined  
24                  under section 1(c) for the taxable year):

**“If the household income (expressed as a percent of poverty line) is:      The applicable dollar amount is:**

|                                        |         |
|----------------------------------------|---------|
| Less than 200% .....                   | \$600   |
| At least 200% but less than 300% ..... | \$1,500 |
| At least 300% but less than 400% ..... | \$2,500 |

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

2               “(1) ADVANCE PAYMENT PROGRAM.—

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

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

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

21                       “(B) PROGRAM REQUIREMENTS.—Such  
22           program shall be established under rules similar

1 to the rules of section 1412 of the Patient Pro-  
 2 tection and Affordable Care Act, as in effect on  
 3 the day before the date of the enactment of this  
 4 section, except that advance determinations and  
 5 advance payments shall be made on request of  
 6 the individual with respect to whom the deter-  
 7 mination is to be made.

8 “(2) INFORMATION REQUIREMENTS.—

9 “(A) IN GENERAL.—Each person providing  
 10 insurance coverage which constitutes medical  
 11 care, and each trustee of a health savings ac-  
 12 count, shall provide the following information to  
 13 the Secretary and to the taxpayer with respect  
 14 to such coverage or such account:

15 “(i) The total premium for the cov-  
 16 erage without regard to the credit under  
 17 this section.

18 “(ii) The aggregate amount of any ad-  
 19 vance payment of such credit made with  
 20 respect to such coverage or to such ac-  
 21 count.

22 “(iii) The name, address, age, and  
 23 TIN of the primary insured or account  
 24 holder (as the case may be) and the name,  
 25 age, and TIN of each other individual ob-

1           taining coverage under such policy of in-  
 2           surance.

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

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

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

12          “(3) INDEXING.—

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

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

1 “(ii) the current dollar gross domestic  
 2 product (as so determined) for the second  
 3 quarter of 2015.

4 “(B) ROUNDING.—If any dollar amount  
 5 adjusted under subparagraph (A) is not a mul-  
 6 tiple of \$50, such amount shall be rounded to  
 7 the next lowest multiple of \$50.

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

9 “(1) CREDITABLE COVERAGE.—The term ‘cred-  
 10 itable coverage’ has the meaning given such term for  
 11 purposes of title XXVII of the Public Health Service  
 12 Act.

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

17 (b) ELECTION BY EMPLOYER TO MAKE EXCISE TAX  
 18 APPLICABLE AND TO BE GOVERNED SOLELY BY EXCLU-  
 19 SION REGIME.—

20 (1) IN GENERAL.—If an eligible employer  
 21 makes the election under this subsection (at such  
 22 time and in such form and manner as the Secretary  
 23 shall prescribe) the tax imposed by section 4980I of  
 24 the Internal Revenue Code of 1986 shall apply to  
 25 any excess benefit with respect to employer-spon-

1       sored health coverage provided by such employer and  
2       the credit and recapture under section 36C of such  
3       Code shall not apply with respect to individuals cov-  
4       ered by such coverage. Such election, once made,  
5       may be revoked only with the consent of the Sec-  
6       retary.

7           (2) ELIGIBLE EMPLOYER.—For purposes of  
8       this subsection, the term “eligible employer” means  
9       an employer in existence before the date of the en-  
10      actment of this Act.

11          (3) CONTROLLED GROUPS.—For purposes of  
12      this subsection, all persons treated as a single em-  
13      ployer under subsection (a) or (b) of section 52 of  
14      the Internal Revenue Code of 1986 or subsection  
15      (m) or (o) of section 414 of such Code shall be  
16      treated as a single eligible employer.

17          (4) REGULATIONS.—The Secretary of the  
18      Treasury shall prescribe such regulations as may be  
19      necessary to prevent the avoidance of the purposes  
20      of this subsection.

21      (c) EXCISE TAX ON HIGH COST EMPLOYER-SPON-  
22      SORED HEALTH INSURANCE ONLY TO APPLY TO EM-  
23      PLOYERS MAKING ELECTION.—Section 4980I(d)(1)(B) of  
24      such Code (relating to exceptions) is amended by striking  
25      “or” at the end of clauses (i) and (ii), by striking the pe-



1 riod at the end of clause (iii) and inserting “, or”, and  
 2 by adding at the end the following new clause:

3 “(iv) any group health plan made  
 4 available by an employer which does not  
 5 have in effect an election under section  
 6 131(b) of the World’s Greatest Healthcare  
 7 Plan Act of 2016.”.

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

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

19 (e) GUIDANCE.—The Secretary of the Treasury shall  
 20 issue such guidance as is necessary—

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

1           (2) to require employers to report to each em-  
 2       ployee with respect to periods not longer than quar-  
 3       terly the employer-provided health insurance tax  
 4       subsidy (as defined in section 36C(c)(3) of such  
 5       Code) with respect to such employee for such period.

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

“Sec. 36C. Universal health insurance tax credit.”.

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

14      **SEC. 132. APPLICATION OF PORTION OF UNUSED TAX**  
 15                               **CREDITS BY STATES FOR INDIGENT HEALTH**  
 16                               **CARE.**

17       (a) COMPUTATION OF UNUSED CREDITS.—The Sec-  
 18      retary, in consultation with the Secretary of the Treasury,  
 19      shall calculate for each State for each year, beginning with  
 20      2017, using the most recent data available —

21           (1) the maximum aggregate amount of credits  
 22      under section 36C of the Internal Revenue Code of  
 23      1986 that would have been allowed for the year for  
 24      qualified residents of the State for taxable years

1 ending in the year if all eligible qualified residents  
 2 had qualified for such credits;

3 (2) the aggregate amount of credits under such  
 4 section that were allowed for taxable years ending in  
 5 that year by qualified residents of such State; and

6 (3) 25 percent of the amount by which—

7 (A) the amount determined under para-  
 8 graph (1) with respect to qualified residents of  
 9 the State for such year; exceeds

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

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

20 (c) GRANTS TO STATES FOR INDIGENT ASSIST-  
 21 ANCE.—

22 (1) APPLICATION.—A State may file with the  
 23 Secretary (in a form and manner specified by the  
 24 Secretary) an application to provide assistance in  
 25 furnishing health services to indigent individuals re-

siding in the State. Such application shall demonstrate the manner in which such assistance is furnished in an equitable manner to individuals residing in all parts of the State.

(2) AMOUNT OF FUNDS.—From the funds appropriated under subsection (b) for a year, the amount of funds paid to any State in any year under this section with an application filed in accordance with paragraph (1) is equal to an amount specified in the application, but not to exceed the amount computed under subsection (a)(3) for the State and the year.

(3) USE OF FUNDS.—Funds paid to a State under this subsection may be used only to assist in the furnishing of health services to uninsured individuals residing in the State or for purposes of increasing the payment adjustments made under sections 1886(d)(5)(F) and 1923 of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F), 1396r-4) to hospitals that serve a disproportionate share of such individuals in the State.

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

(1) USE OF ESTIMATES.—The calculations under subsection (a) for a year shall initially be esti-

1 mated before the beginning of the year. Payments  
 2 under this section to a State for a year shall be  
 3 made, subject to reconciliation under paragraph (2),  
 4 based on the amount so estimated.

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

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

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

1 sisting of coverage under a health plan that qualifies for  
2 a tax credit under section 36C of the Internal Revenue  
3 Code of 1986, but only if, for each year the individual  
4 receives medical assistance in the form of such coverage,  
5 the State also deposits into a health savings account for  
6 the individual an amount equal to the amount (if any) by  
7 which the amount of the tax credit for the individual under  
8 such section exceeds the cost of coverage of the individual  
9 under the plan.

10 (b) FFP TREATMENT.—The payments by a State de-  
11 scribed in subsection (a) for coverage under a health plan  
12 and for deposit into a health savings account shall be  
13 treated as medical assistance for purposes of section 1903  
14 of the Social Security Act (42 U.S.C. 1396b) and section  
15 1903A of such Act (as added by section 401) and subject  
16 to Federal financial participation, including the applica-  
17 tion of State matching payments, in the same manner as  
18 other medical assistance furnished under title XIX of such  
19 Act, except that such amount shall be reduced by the  
20 amount of any health insurance credits provided under  
21 section 36C of the Internal Revenue Code of 1986 with  
22 respect to such coverage or deposit.

1 **TITLE II—IMPROVING HEALTH**  
 2 **SAVINGS ACCOUNTS TO PRO-**  
 3 **MOTE ACCOUNTABILITY**

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

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

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

“Sec. 530A. Roth HSAs.

9 **“SEC. 530A. ROTH HSAS.**

10 “(a) IN GENERAL.—With the exception of the taxes  
 11 imposed by section 511 (relating to imposition of tax on  
 12 unrelated business income of charitable organizations), a  
 13 Roth HSA shall be exempt from taxation under this sub-  
 14 title. No deduction shall be allowed for any contribution  
 15 to a Roth HSA.

16 “(b) DOLLAR LIMITATION.—

17 “(1) IN GENERAL.—The aggregate amount of  
 18 contributions for any taxable year to all Roth HSAs  
 19 maintained for the benefit of an individual shall not  
 20 exceed the sum of the monthly limitations for any  
 21 month during such taxable year that the individual  
 22 is an eligible individual.

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

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

4           “(B) in the case of an eligible individual  
5           who has family creditable coverage as of the  
6           first day of such month, the amount in effect  
7           under subparagraph (A) for the taxable year  
8           multiplied by the number of individuals (includ-  
9           ing the eligible individual) covered under such  
10          family creditable coverage as of such day.

11          “(3) ADDITIONAL CONTRIBUTIONS FOR INDIVIDUALS 55 OR OLDER.—In the case of an individual  
12          who has attained age 55 before the close of the tax-  
13          able year, the applicable limitation under subpara-  
14          graphs (A) and (B) of paragraph (2) shall be in-  
15          creased by \$1,000.

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

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

24                 “(B) the aggregate amount contributed to  
25                 Roth HSAs of such individual which is exclud-



1           able from the taxpayer’s gross income for such  
 2           taxable year under section 106(d) (and such  
 3           amount shall not be allowed as a deduction  
 4           under subsection (a)), and

5           “(C) the aggregate amount contributed to  
 6           Roth HSAs of such individual for such taxable  
 7           year under section 408(d)(9) (and such amount  
 8           shall not be allowed as a deduction under sub-  
 9           section (a)).

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

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

15               “(A) both spouses shall be treated as hav-  
 16               ing only such family coverage (and if such  
 17               spouses each have family coverage under dif-  
 18               ferent plans, as having the family coverage with  
 19               the lowest annual deductible), and

20               “(B) the limitation under paragraph (1)  
 21               (after the application of subparagraph (A) and  
 22               without regard to any additional contribution  
 23               amount under paragraph (3))—

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

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

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

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

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

23 “(A) IN GENERAL.—For purposes of com-  
 24 puting the limitation under paragraph (1) for  
 25 any taxable year, an individual who is an eligi-

ble individual during the last month of such taxable year shall be treated—

“(i) as having been an eligible individual during each of the months in such taxable year, and

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

“(B) FAILURE TO MAINTAIN CREDITABLE COVERAGE.—

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

“(I) the gross income of the individual for the taxable year in which occurs the first month in the testing period for which such individual is not an eligible individual shall be increased by the aggregate amount of all contributions to the Roth HSA of the individual which could not have

1                   been made but for subparagraph (A),  
2                   and

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

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

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

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

21                  “(1) IN GENERAL.—The term ‘Roth HSA’  
22                  means a trust created or organized in the United  
23                  States as a Roth HSA exclusively for the purpose of  
24                  paying the qualified medical expenses of the account  
25                  beneficiary, but only if the written governing instru-

1       ment creating the trust meets the following require-  
2       ments:

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

7                       “(i) unless it is in cash, or

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

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

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

16               “(B) The trustee is a bank (as defined in  
17       section 408(n)), an insurance company (as de-  
18       fined in section 816), or another person who  
19       demonstrates to the satisfaction of the Sec-  
20       retary that the manner in which such person  
21       will administer the trust will be consistent with  
22       the requirements of this section.

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

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

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

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

9           “(A) IN GENERAL.—The term ‘qualified  
10           medical expenses’ means, with respect to an ac-  
11           count beneficiary, amounts paid by such bene-  
12           ficiary for medical care (as defined in section  
13           213(d) as in effect on the day before the date  
14           of the enactment of the World’s Greatest  
15           Healthcare Plan Act of 2016) for such indi-  
16           vidual, the spouse of such individual, and any  
17           dependent (as defined in section 152, deter-  
18           mined without regard to subsections (b)(1),  
19           (b)(2), and (d)(1)(B) thereof) of such indi-  
20           vidual, but only to the extent such amounts are  
21           not compensated for by insurance or otherwise.

22           “(B) LIMITATION ON HEALTH INSURANCE  
23           PURCHASED FROM ACCOUNT.—Such term shall  
24           not include any payment for health benefits cov-

1           erage that is not creditable coverage (as defined  
2           in section 36C).

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

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

9                   “(ii) a qualified long-term care insur-  
10                  ance contract (as defined in section  
11                  7702B(b)),

12                  “(iii) a health plan during a period in  
13                  which the individual is receiving unemploy-  
14                  ment compensation under any Federal or  
15                  State law, or

16                  “(iv) in the case of an account bene-  
17                  ficiary who has attained the age specified  
18                  in section 1811 of the Social Security Act,  
19                  any health insurance other than a medi-  
20                  care supplemental policy (as defined in sec-  
21                  tion 1882 of the Social Security Act).

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

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

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

6                   “(B) Except as provided in section 106(d),  
7                   section 219(f)(5) (relating to employer pay-  
8                   ments).

9                   “(C) Section 408(g) (relating to commu-  
10                  nity property laws).

11                  “(D) Section 408(h) (relating to custodial  
12                  accounts).

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

15                   “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible  
16                   individual’ means, with respect to any month, any  
17                   individual who is covered under creditable coverage  
18                   as of the 1st day of such month.

19                   “(2) CREDITABLE COVERAGE.—The term ‘cred-  
20                   itable coverage’ shall have the meaning given such  
21                   term in section 36C(f)(1).

22           “(e) TAX TREATMENT OF DISTRIBUTIONS.—

23                   “(1) AMOUNTS USED FOR QUALIFIED MEDICAL  
24                   EXPENSES.—Any amount paid or distributed out of  
25                   a Roth HSA which is used exclusively to pay quali-



1       fied medical expenses of any account beneficiary  
2       shall not be includible in gross income.

3           “(2) INCLUSION OF AMOUNTS NOT USED FOR  
4       QUALIFIED MEDICAL EXPENSES.—Any amount paid  
5       or distributed out of a Roth HSA which is not used  
6       exclusively to pay the qualified medical expenses of  
7       the account beneficiary shall be included in the gross  
8       income of such beneficiary.

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

11           “(A) IN GENERAL.—If any excess con-  
12      tribution is contributed for a taxable year to  
13      any Roth HSA of an individual, paragraph (2)  
14      shall not apply to distributions from the Roth  
15      HSAs of such individual (to the extent such dis-  
16      tributions do not exceed the aggregate excess  
17      contributions to all such accounts of such indi-  
18      vidual for such year) if—

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

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

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

7 “(B) EXCESS CONTRIBUTION.—For pur-  
 8 poses of subparagraph (A), the term ‘excess  
 9 contribution’ means any contribution (other  
 10 than a rollover contribution described in para-  
 11 graph (5) or section 220(f)(5)) which exceeds  
 12 the contribution limitation with respect to the  
 13 individual for the taxable year.

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

16 “(A) IN GENERAL.—The tax imposed by  
 17 this chapter on the account beneficiary for any  
 18 taxable year in which there is a payment or dis-  
 19 tribution from a Roth HSA of such beneficiary  
 20 which is includible in gross income under para-  
 21 graph (2) shall be increased by 10 percent of  
 22 the amount which is so includible.

23 “(B) EXCEPTION FOR DISABILITY OR  
 24 DEATH.—Subparagraph (A) shall not apply if  
 25 the payment or distribution is made after the

1 account beneficiary becomes disabled within the  
2 meaning of section 72(m)(7) or dies.

3 “(C) EXCEPTION FOR DISTRIBUTIONS  
4 AFTER MEDICARE ELIGIBILITY.—Subparagraph  
5 (A) shall not apply to any payment or distribu-  
6 tion after the date on which the account bene-  
7 ficiary attains the age specified in section 1811  
8 of the Social Security Act.

9 “(5) ROLLOVER CONTRIBUTION.—An amount is  
10 described in this paragraph as a rollover contribu-  
11 tion if it meets the requirements of subparagraphs  
12 (A) and (B).

13 “(A) IN GENERAL.—Paragraph (2) shall  
14 not apply to any amount paid or distributed  
15 from a health savings account (as defined in  
16 section 223) or a Roth HSA to the account  
17 beneficiary to the extent the amount received is  
18 paid into a Roth HSA for the benefit of such  
19 beneficiary not later than the 60th day after  
20 the day on which the beneficiary receives the  
21 payment or distribution.

22 “(B) LIMITATION.—This paragraph shall  
23 not apply to any amount described in subpara-  
24 graph (A) received by an individual from a  
25 health savings account or a Roth HSA if, at

1 any time during the 1-year period ending on the  
2 day of such receipt, such individual received any  
3 other amount described in subparagraph (A)  
4 from a health savings account or Roth HSA  
5 which was not includible in the individual's  
6 gross income because of the application of this  
7 paragraph.

8 “(6) TRANSFER OF ACCOUNT INCIDENT TO DI-  
9 VORCE.—The transfer of an individual's interest in  
10 a Roth HSA to an individual's spouse or former  
11 spouse under a divorce or separation instrument de-  
12 scribed in subparagraph (A) of section 71(b)(2) shall  
13 not be considered a taxable transfer made by such  
14 individual notwithstanding any other provision of  
15 this subtitle, and such interest shall, after such  
16 transfer, be treated as a Roth HSA with respect to  
17 which such spouse is the account beneficiary.

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

24 “(f) COST-OF-LIVING ADJUSTMENT.—

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

5                   “(A) such dollar amount, multiplied by

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

9                           “(i) by substituting ‘calendar year  
10                           2015’ for ‘calendar year 1992’ in subpara-  
11                           graph (B) thereof, and

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

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

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

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

24                   “(1) the trustee of a Roth HSA to make such  
25                   reports regarding such account to the Secretary and

1 to the account beneficiary with respect to contribu-  
 2 tions, distributions, the return of excess contribu-  
 3 tions, and such other matters as the Secretary deter-  
 4 mines appropriate, and

5 “(2) any person who provides an individual with  
 6 creditable coverage to make such reports to the Sec-  
 7 retary and to the account beneficiary with respect to  
 8 such plan as the Secretary determines appropriate.

9 The reports required by this subsection shall be filed at  
 10 such time and in such manner and furnished to such indi-  
 11 viduals at such time and in such manner as may be re-  
 12 quired by the Secretary.”.

13 (b) LIMIT ON CONTRIBUTIONS TO DEDUCTIBLE  
 14 HEALTH SAVINGS ACCOUNTS.—Section 223 of such Code  
 15 is amended by adding at the end the following new sub-  
 16 section:

17 “(i) LIMITED CONTRIBUTIONS AFTER 2016.—

18 “(1) IN GENERAL.—No contribution may be ac-  
 19 cepted by a health savings account after December  
 20 31, 2016.

21 “(2) EXCEPTIONS.—Paragraph (1) shall not  
 22 apply—

23 “(A) in the case of a rollover contribution  
 24 described in subsection (f)(5) or section  
 25 220(f)(5), or

## PART IX. ROTH HEALTH SAVINGS ACCOUNTS.

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

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

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

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

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

10   **SEC. 204. TREATMENT OF DIRECT PRIMARY CARE.**

11       (a) HSAs.—

12           (1) ROTH HSA.—Section 530A(c)(2)(A) of the  
 13       Internal Revenue Code of 1986, as added by this  
 14       Act, is amended by adding at the end the following:  
 15       “Such term shall include the payment of a monthly  
 16       or other prepaid amount for the furnishing (or ac-  
 17       cess to the furnishing) by a physician or group of  
 18       physicians of physician professional services (and an-  
 19       cillary services).”.

20           (2) HSA.—Section 223(d)(2)(A) of such Code  
 21       is amended by adding at the end the following:  
 22       “Such term shall include the payment of a monthly  
 23       or other prepaid amount for the furnishing (or ac-  
 24       cess to the furnishing) by a physician or group of



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

3 (b) NOT TREATED AS HEALTH INSURANCE COV-  
 4 ERAGE.—

5 (1) IN GENERAL.—For purposes of title XXVII  
 6 of the Public Health Service Act, subtitle B of title  
 7 I of the Employee Retirement and Income Security  
 8 Act of 1974, PPACA, and this Act, the offering of  
 9 direct primary care shall not be treated as the offer-  
 10 ing of health insurance coverage and shall not be  
 11 subject to regulations as such coverage under such  
 12 Acts.

13 (2) DIRECT PRIMARY CARE DEFINED.—In this  
 14 subsection, the term “direct primary care” means  
 15 the furnishing (or access to the furnishing) by a  
 16 physician or group of physicians of physician profes-  
 17 sional services (and ancillary services) in return for  
 18 payment of a monthly or other prepaid amount.

## 19 **TITLE III—STATE FLEXIBILITY** 20 **IN REGULATION OF HEALTH** 21 **INSURANCE COVERAGE**

### 22 **SEC. 301. STATE FLEXIBILITY IN REGULATION OF HEALTH** 23 **INSURANCE COVERAGE.**

24 (a) IN GENERAL.—States are given the flexibility  
 25 under section 122(b) to revise their regulations of the

1 health insurance marketplace, without regard to many of  
 2 the requirements imposed under PPACA, in order to pro-  
 3 mote freedom of choice of affordable health insurance cov-  
 4 erage options offered outside of an Exchange.

5 (b) CONSTRUCTION.—Nothing in the Employee Re-  
 6 tirement and Income Security Act of 1974 or of any  
 7 amendments made by the Health Insurance Portability  
 8 and Accountability Act of 1996 shall be interpreted as pre-  
 9 venting an employer from offering, or making an employer  
 10 contribution towards, individual health insurance coverage  
 11 for employees and dependent family members.

## 12 **TITLE IV—MEDICAID PAYMENT** 13 **REFORM**

### 14 **SEC. 401. MEDICAID PAYMENT REFORM.**

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

#### 18 **“SEC. 1903A. REFORMED PAYMENT TO STATES.**

19 “(a) REFORMED PAYMENT SYSTEM.—

20 “(1) IN GENERAL.—For quarters beginning on  
 21 or after the implementation date (as defined in sub-  
 22 section (k)(1)), in lieu of amounts otherwise payable  
 23 to a State under this title (including any payments  
 24 attributable to section 1923), except as otherwise

provided in this section, the amount payable to such State shall be equal to the sum of the following:

“(A) ADJUSTED AGGREGATE BENE-  
FICIARY-BASED AMOUNT.—The aggregate bene-  
ficiary-based amount specified in subsection (b)  
for the quarter and the State, adjusted under  
subsection (e).

“(B) CHRONIC CARE QUALITY BONUS.—  
The amount (if any) of the chronic care quality  
bonus payment specified in subsection (f) for  
the quarter for the State.

“(2) REQUIREMENT OF STATE SHARE.—

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

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

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

1 “(ii) the ratio of—

2 “(I) the State percentage de-  
3 scribed in subparagraph (D)(ii) for  
4 such State and fiscal year; to

5 “(II) the Federal percentage de-  
6 scribed in subparagraph (D)(i) for  
7 such State and fiscal year.

8 “(C) NONPAYMENT FOR FAILURE TO PAY  
9 STATE SHARE.—

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

18 “(I) the Federal percentage de-  
19 scribed in subparagraph (D)(i) for  
20 such State and fiscal year; to

21 “(II) the State percentage de-  
22 scribed in subparagraph (D)(ii) for  
23 such State and fiscal year.

24 “(ii) GRACE PERIOD.—A State shall  
25 not be considered to have failed to provide

1 payment of its required State share for a  
 2 quarter under subparagraph (A) if the ag-  
 3 gregate State payment towards the State’s  
 4 required State share for the 4-quarter pe-  
 5 riod beginning with such quarter exceeds  
 6 the required State share amount for such  
 7 4-quarter period.

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

11 “(i) FEDERAL PERCENTAGE.—The  
 12 Federal percentage described in this clause  
 13 is 75 percent or, if higher, the Federal  
 14 medical assistance percentage for such  
 15 State for such fiscal year.

16 “(ii) STATE PERCENTAGE.—The State  
 17 percentage described in this clause is 100  
 18 percent minus the Federal percentage de-  
 19 scribed in clause (i).

20 “(E) RULES FOR CREDITING TOWARD  
 21 STATE SHARE.—

22 “(i) GENERAL LIMITATION TO MATCH-  
 23 ABLE EXPENDITURES.—A payment for ex-  
 24 penditures shall not be counted toward the  
 25 State share under subparagraph (A) unless

1 Federal payments may be used for such  
2 expenditures consistent with paragraph  
3 (3)(B).

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

9 “(I) ABORTION.—Expenditures  
10 for an abortion.

11 “(II) INTERGOVERNMENTAL  
12 TRANSFERS.—An expenditure that is  
13 attributable to an intergovernmental  
14 transfer.

15 “(III) CERTIFIED PUBLIC EX-  
16 PENDITURES.—An expenditure that is  
17 attributable to certified public expend-  
18 itures.

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

1           “(F) CONSTRUCTION.—Nothing in the  
2 paragraph shall be construed as preventing a  
3 State from expending, from non-Federal funds,  
4 an amount under this title in excess of the  
5 amount of the State share.

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

16           “(3) USE OF FEDERAL PAYMENTS.—

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

22           “(B) LIMITATION FOR CERTAIN ELIGI-  
23 BLES.—

24           “(i) APPLICATION OF 100 PERCENT  
25 FEDERAL POVERTY LINE LIMIT ON ELIGI-

1 BILITY.—Subject to clause (iii), a State  
 2 may not use such Federal payments to  
 3 provide medical assistance for an indi-  
 4 vidual who has an income (as determined  
 5 under clause (ii)) that exceeds 100 percent  
 6 of the poverty line (as defined in section  
 7 2110(c)(5)) applicable to a family of the  
 8 size involved.

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

17 “(I) APPLICATION OF SPEND  
 18 DOWN.—The State shall take into ac-  
 19 count the costs incurred for medical  
 20 care or for any other type of remedial  
 21 care recognized under State law in the  
 22 same manner and to the same extent  
 23 that such State takes such costs into  
 24 account for purposes of section  
 25 1902(a)(17).



1 “(II) DISREGARD OF 5 PERCENT  
 2 INCREASE.—Subparagraph (I) of sec-  
 3 tion 1902(e)(14) (relating to a 5 per-  
 4 cent reduction) shall not apply.

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

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

9 “(II) a child who is an individual  
 10 described in clause (i) of section  
 11 1905(a);

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

16 “(IV) described in section  
 17 1902(e)(14)(D) (relating to modified  
 18 adjusted gross income).

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

24 “(4) EXCEPTIONS FOR PASS-THROUGH PAY-  
 25 MENTS.—

“(A) IN GENERAL.—Paragraph (1) shall not apply, and amounts shall continue to be payable under this title (and not under this subsection), in the case of the following payments (and related administrative costs and expenditures):

“(i) PAYMENTS TO TERRITORIES.—Payments to a State other than the 50 States and the District of Columbia.

“(ii) MEDICARE COST SHARING.—Payments attributable to Medicare cost sharing under section 1905(p).

“(iii) PEDIATRIC VACCINES.—Payments attributable to section 1928.

“(iv) EMERGENCY SERVICES FOR CERTAIN INDIVIDUALS.—Payments for treatment of emergency medical conditions attributable to the application of section 1903(v)(2).

“(v) INDIAN HEALTH CARE FACILITIES.—Payments for medical assistance described in the third sentence of section 1905(b).

“(vi) EMPLOYER-SPONSORED INSURANCE (ESI).—Payments for medical assist-

1           ance attributable to payments to employers  
 2           for employer-sponsored health benefits cov-  
 3           erage.

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

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

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

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

1                   “(iii) PAYMENTS FOR DESIGN, DEVEL-  
 2                   OPMENT, AND INSTALLATION OF MMIS AND  
 3                   ELIGIBILITY SYSTEMS.—Payments under  
 4                   subparagraphs (A)(i) and (H)(i) of section  
 5                   1903(a)(3) for expenditures for design, de-  
 6                   velopment, and installation of the Medicaid  
 7                   management information systems and  
 8                   mechanized verification and information  
 9                   retrieval systems (related to eligibility).

10                  “(5) PAYMENT OF AMOUNTS.—

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

17                   “(B) INFORMATION AND FORMS.—

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

1                   “(ii) UNIFORM REPORTING.—The  
 2                   Secretary shall develop such forms as may  
 3                   be needed to assure a system of uniform  
 4                   reporting of such information across  
 5                   States.

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

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

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

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

24               “(B) NUMBER OF INDIVIDUALS IN CAT-  
 25               EGORY.—Subject to subsection (d), the average

1           number of Medicaid beneficiaries enrolled in  
2           such category in the State in such quarter.

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

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

7                   “(B) BLIND OR DISABLED.—A category of  
8                   Medicaid beneficiaries not described in subpara-  
9                   graph (A) who are described in section  
10                  1937(a)(2)(B)(ii).

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

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

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

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

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

such category determined under paragraph (2),  
increased by a factor that reflects the sum of  
the following:

“(i) HISTORICAL MEDICAL CARE COMPONENT OF CPI THROUGH PREVIOUS REFORM YEAR.—The percentage increase in the historical medical care component of the Consumer Price Index for all urban consumers (U.S. city average) from the midpoint of the base fiscal year (as defined in paragraph (6)) to the midpoint of the fiscal year preceding the first reform year.

“(ii) PROJECTED MEDICAL CARE COMPONENT OF CPI FOR THE FIRST REFORM YEAR.—The percentage increase in the projected medical care component of the Consumer Price Index for all urban consumers (U.S. city average) from the midpoint of the previous fiscal year referred to in clause (i) to the midpoint of the first reform year.

“(B) SECOND AND THIRD REFORM YEARS.—The beneficiary-based quarterly amount for a State for a category for quarters in the second reform year or the third reform

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

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

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

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



1           increase for such category and reform  
2           year.

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

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

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

24                 “(ii) one percentage point.

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

3           “(A) AVERAGE PER CATEGORY.—

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

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

23                   “(iii) UPDATES.—The determination  
24                   under clause (i) shall be updated by the  
25                   Secretary on an annual basis based upon

1 improved data. The Secretary shall adjust  
2 the amounts under subsection (a)(1)(A) to  
3 reflect changes in the amounts so deter-  
4 mined based on such updates.

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

10 “(C) STANDARDIZATION.—

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

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

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

1                   “(ii) METHOD OF STANDARDIZA-  
2                   TION.—

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

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

1 “(III) METHOD FOR GEOGRAPHIC  
2 STANDARDIZATION.—The Secretary  
3 shall apply the standardization under  
4 clause (i)(II) in a manner similar to  
5 that applied under section  
6 1853(c)(4)(A)(iii).

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

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

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

1           “(D) ADJUSTMENT FOR TEMPORARY FMAP  
 2           INCREASES.—In computing each base per bene-  
 3           ficiary, per category amounts under subpara-  
 4           graph (A)(i) the Secretary shall disregard por-  
 5           tions of payments that are attributable to a  
 6           temporary increase in the Federal matching  
 7           rates, including those attributable to the fol-  
 8           lowing:

9                   “(i) PPACA DISASTER FMAP.—Sec-  
 10                  tion 1905(aa).

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

14                  “(iii) EXTRAORDINARY EMPLOYER  
 15                  PENSION CONTRIBUTION.—Section 614 of  
 16                  the Children’s Health Insurance Program  
 17                  Reauthorization Act of 2009 (42 U.S.C.  
 18                  1396d note).

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

1           “(A) among different categories of bene-  
2           ficiaries; and

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

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

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

20          “(B) TRANSITION ADJUSTMENT.—

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

for a quarter in a reform year (beginning with the fourth reform year and ending with the tenth reform year) is equal to the sum of—

“(I) the product of the State-specific factor for such reform year (as defined in clause (iv)) and the beneficiary-based quarterly amount that would otherwise be determined under paragraph (1) for such State and category if the State were a State described in clause (ii) of paragraph (1)(C), instead of a State described in clause (i) of such paragraph; and

“(II) the product of 1 minus the State-specific factor for such reform year and the beneficiary-based quarterly amount that would otherwise be determined under paragraph (1) for a State and category if the base per beneficiary, per category amount determined under paragraph (2) for the State and category were equal to 110 percent of the national average base per beneficiary, per category amount



1                   determined under subparagraph (A)  
 2                   for such category.

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

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

22                   “(II) the product of 1 minus the  
 23                  State-specific factor for such reform  
 24                  year and the beneficiary-based quar-  
 25                  terly amount that would otherwise be

determined under paragraph (1) for a State and category if the base per beneficiary, per category amount determined under paragraph (2) for the State and category were equal to 90 percent of the national average base per beneficiary, per category amount determined under subparagraph (A) for such category.

“(iii) HIGH AND LOW PER BENEFICIARY STATES DEFINED.—In this subparagraph:

“(I) HIGH PER BENEFICIARY STATE.—The term ‘high per beneficiary State’ means, with respect to a category, a State for which the base per beneficiary, per category amount determined under paragraph (2) for such category is greater than 110 percent of the national average base per beneficiary, per category amount determined under subparagraph (A) for such category.

“(II) LOW PER BENEFICIARY STATE.—The term ‘low per bene-

ficiary State' means, with respect to a category, a State for which the base per beneficiary, per category amount determined under paragraph (2) for such category is less than 90 percent of the national average base per beneficiary, per category amount determined under subparagraph (A) for such category.

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

“(I) for the fourth reform year,

$\frac{7}{8}$ ; and

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

“(C) NO ADDITIONAL EXPENDITURES.—

“(i) DETERMINATION OF INCREASE IN FEDERAL EXPENDITURES.—For each category for each reform year (beginning with the fourth reform year and ending with the tenth reform year), the Secretary shall de-

1           termine whether the application of this  
2           paragraph—

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

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

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

1                   penditure increase described in clause  
2                   (i)(II) for the reform year.

3                   “(5) REPORTS ON PER BENEFICIARY RATES;  
4           APPEALS.—

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

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

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

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

23                  “(C) DETERMINATION ON APPEAL.—Not  
24                  later than 3 months after receiving such an ap-  
25                  peal, the Secretary shall make a final deter-

1           mination on such amounts for such State. If no  
 2           such appeal is received for a State, the Sec-  
 3           retary's initial determination under subpara-  
 4           graph (A)(i) shall become final.

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

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

18          “(e) RISK ADJUSTMENT.—

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

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

4 “(B) variations in costs on a county-by-  
 5 county basis for medical assistance and admin-  
 6 istrative expenses.

7 “(2) METHOD OF ADJUSTMENT.—

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

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

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

23 “(1) DETERMINATION OF BONUS PAYMENTS.—

24 If the Secretary determines that, based on the re-  
 25 ports under paragraph (5), with respect to cat-

egories of chronic disease for which chronic care performance targets had been established under paragraph (3) for each category of Medicaid beneficiaries specified under subsection (b)(2) such targets have been met by a State for a reform year, the Secretary shall make an additional payment to such State in the amount specified in paragraph (6) for each quarter in the succeeding reform year. Such payments shall be made in a manner specified by the Secretary and may only be used consistent with subsection (a)(3).

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

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

“(A) SYSTEM AND DATA.—With respect to the categories of chronic disease under paragraph (2), the Secretary shall adopt a quality measurement system that uses data described in paragraph (4) and is similar to the Five-Star Quality Rating System used to indicate the per-



1 formance of Medicare Advantage plans under  
 2 part C of title XVIII.

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

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

17 “(A) data collected through methods such  
 18 as—

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

23 “(ii) the ‘Consumer Assessment of  
 24 Healthcare Providers and Systems’ (also  
 25 known as ‘CAHPS’) (or an appropriate

1 successor performance measurement tool);

2 and

3 “(iii) the ‘Health Outcomes Survey’

4 (also known as ‘HOS’) (or an appropriate

5 successor performance measurement tool);

6 and

7 “(B) other data collected by the State.

8 “(5) REPORTS.—

9 “(A) IN GENERAL.—Each State shall col-  
 10 lect, analyze, and report to the Secretary, at a  
 11 frequency and in a manner to be established by  
 12 the Secretary, data described in paragraph (4)  
 13 that permit the Secretary to monitor the State’s  
 14 performance relative to the chronic care per-  
 15 formance targets established under paragraph  
 16 (3).

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

22 “(6) AMOUNT OF BONUS PAYMENTS.—

23 “(A) IN GENERAL.—Subject to subpara-  
 24 graphs (B) and (C), with respect to each cat-  
 25 egory of Medicaid beneficiaries, in the case of

1 a State that the Secretary determines, based on  
2 the chronic care performance targets set under  
3 paragraph (3) for a reform year for such cat-  
4 egory, performs—

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

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

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

viduals enrolled under the plan within such category;

“(iv) in the next five States in such category, subject to clauses (i) and (iii) of subparagraph (C), the amount of the bonus for each such quarter shall be 2 percent of the payment amount otherwise paid to the State under subsection (a) for individuals enrolled under the plan within such category; and

“(v) in the next five States in such category, subject to clauses (i) and (iii) of subparagraph (C), the amount of the bonus for each such quarter shall be 1 percent of the payment amount otherwise paid to the State under subsection (a) for individuals enrolled under the plan within such category.

“(B) AGGREGATE ANNUAL LIMIT FOR EACH CATEGORY OF MEDICAID BENEFICIARIES.—

“(i) IN GENERAL.—In no case may the aggregate amount of bonuses under this subsection for quarters in a reform year for a category of Medicaid bene-

1           ficiaries exceed the limit specified in clause  
2           (ii) for the reform year.

3           “(ii) LIMIT.—The limit specified in  
4           this clause—

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

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

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

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

ified in subparagraph (B)(ii) for the reform year.

“(ii) PRORATION FOR FIRST TWO TIERS.—If the aggregate amount of bonuses under clauses (i) and (ii) of subparagraph (A) for a category of Medicaid beneficiaries for quarters in a reform year exceeds the limit specified in subparagraph (B)(ii) for the reform year, the amount of each such bonus shall be prorated in a manner so the aggregate amount of such bonuses is equal to such limit.

“(iii) PRORATION FOR NEXT THREE TIERS.—If the aggregate amount of bonuses under clauses (i) and (ii) of subparagraph (A) for a category of Medicaid beneficiaries for quarters in a reform year is less than the limit specified in subparagraph (B)(ii) for the reform year, but the aggregate amount of bonuses under clauses (i) through (v) of subparagraph (A) for the category and such quarters in the reform year exceeds the limit specified in subparagraph (B)(ii) for the reform year, the amount of each bonus in clauses (iii), (iv),

1                   and (v) of subparagraph (A) shall be pro-  
 2                   rated in a manner so the aggregate  
 3                   amount of all the bonuses under subpara-  
 4                   graph (A) is equal to such limit.

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

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

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

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

22           “(2) PROVIDER PAYMENT REQUIREMENT.—

23           “(A) IN GENERAL.—A State electing the  
 24   option under this subsection shall provide pay-  
 25   ment to health care providers for the items and

1 services described under paragraph (1)(B) at a  
 2 rate that is not less than the rate at which pay-  
 3 ments would be made to such providers for such  
 4 items and services under title XVIII.

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

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

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

24 “(B) the Secretary shall pay to the State,  
 25 in addition to the amounts paid to such State



1 under subsection (a), the amount that the Sec-  
 2 retary would, but for this subsection, otherwise  
 3 pay under title XVIII for items and services  
 4 furnished to such an individual in such State  
 5 for such quarters.

6 “(4) FULL-BENEFIT DUAL ELIGIBLE INDIVIDUAL  
 7 DEFINED.—In this subsection, the term  
 8 ‘full-benefit dual eligible individual’ means an indi-  
 9 vidual who meets the requirements of section  
 10 1935(c)(6)(A)(ii).

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

16 “(i) TREATMENT OF WAIVERS.—

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

24 “(2) APPLICATION OF BUDGET NEUTRALITY TO  
 25 SUBSEQUENT WAIVERS AND RENEWALS TAKING SEC-

1       TION INTO ACCOUNT.—In the case of a waiver of re-  
 2       quirements of this title pursuant to section 1115 or  
 3       other law that is approved or renewed after the date  
 4       of the enactment of this section, to the extent that  
 5       such approval or renewal is conditioned upon a dem-  
 6       onstration of budget neutrality, budget neutrality  
 7       shall be determined taking into account the applica-  
 8       tion of this section.

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

12      “(k) DEFINITIONS.—In this section:

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

15                   “(A) July 1, 2017, if this section is en-  
 16                   acted on or before July 1, 2016; or

17                   “(B) July 1, 2018, if this section is en-  
 18                   acted after July 1, 2016.

19           “(2) REFORM YEARS.—

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

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

“(C) The terms ‘second’, ‘third’, and successive similar terms mean, with respect to a reform year, the second, third, or successive reform year, respectively, succeeding the first reform year.”.

(b) CONFORMING AMENDMENTS.—

(1) CONTINUED APPLICATION OF CLAWBACK PROVISIONS.—

(A) CONTINUED APPLICATION.—Subsections (a) and (c)(1)(C) of section 1935 of such Act (42 U.S.C. 1396u–5) are each amended by inserting “or 1903A(a)” after “1903(a)”.

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

(2) PAYMENT RULES UNDER SECTION 1903.—

(A) Section 1903(a) of such Act (42 U.S.C. 1396b(a)) is amended, in the matter before paragraph (1), by inserting “and section 1903A” after “except as otherwise provided in this section”.

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

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

(ii) in paragraph (2)—

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

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

(iii) in paragraph (4)—

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

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

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

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

1           (4) REPORT ON ADDITIONAL CONFORMING  
 2 AMENDMENTS NEEDED.—Not later than 6 months  
 3 after the date of the enactment of this Act, the Sec-  
 4 retary of Health and Human Services shall submit  
 5 to Congress a report that includes a description of  
 6 any additional technical and conforming amend-  
 7 ments to law that are required to properly carry out  
 8 this Act.

9 **TITLE V—INCREASING PRICE**  
 10 **TRANSPARENCY AND FREE-**  
 11 **DOM OF PRACTICE**

12 **SEC. 501. ENSURING ACCESS TO EMERGENCY SERVICES**  
 13 **WITHOUT EXCESSIVE CHARGES FOR OUT-OF-**  
 14 **NETWORK SERVICES.**

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

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

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

1 shall apply to a civil money penalty under this para-  
 2 graph in the same manner as such provisions apply  
 3 with respect to a penalty or proceeding under section  
 4 1128A(a).”; and

5 (2) by adding at the end the following new sub-  
 6 section:

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

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

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

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

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

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

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

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

22 “(C) DRUGS AND BIOLOGICALS.—For  
23 drugs and other pharmaceuticals furnished to  
24 which a previous subparagraph does not apply,  
25 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(f)(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, 2017.

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 this Act, is amended by adding at the end  
13 the following new subparagraph:

14 “(E) Section 223(f)(9) (relating to cash  
15 price transparency required for payments to  
16 health care providers).”.

17 (c) ENFORCEMENT.—If the Secretary determines  
18 that a health care provider has not provided for continuing  
19 disclosure of the cash price of health care provider charges  
20 under section 223(f)(9) of the Internal Revenue Code of  
21 1986, the Secretary may instruct the Secretary of the  
22 Treasury that payments made to such provider shall be  
23 not treated, for purposes of section 223 of the Internal  
24 Revenue Code of 1986, as an amount used for a qualified  
25 medical expense for a period of not to exceed 1 year.

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

4 **SEC. 503. LIBERATING THE LOCAL PRACTICE OF HEALTH**  
 5 **CARE.**

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

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

15 “(1) increase competition within the health care  
 16 market;

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

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

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

21 (1) APPLICATION FOR WAIVER OF RESTRIC-  
 22 TIONS.—An individual who is required to be licensed  
 23 or certified by a State as a condition of furnishing  
 24 items or services as a health care professional (as  
 25 defined by the Secretary of Health and Human

1 Services) may submit to the Secretary an application  
2 to waive any condition of such licensure or certifi-  
3 cation.

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

7 (A) increase competition within the health  
8 care market;

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

10 (C) increase the quality of health care.

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

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