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115TH CONGRESS
1ST SESSION

H. R. 1275

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

IN THE HOUSE OF REPRESENTATIVES

MARCH 1, 2017

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

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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.

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

SECTION 1. SHORT TITLE; PURPOSES; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''World's Greatest Healthcare Plan of 2017''.

(b) PURPOSES.—The purposes of this Act are as follows:

(1) ELIMINATION OF INDIVIDUAL AND EMPLOYER MANDATES UNDER ACA.—To eliminate mandates on individuals and employers, and other tax requirements, imposed under Patient Protection and Affordable Care Act.

(2) PROVIDING STATES WITH ALTERNATIVE, AFFORDABLE COVERAGE OPTIONS.—To provide greater flexibility in providing States with options in making affordable health insurance coverage available by eliminating certain mandates under PPACA, while retaining essential consumer protections, by promoting health savings accounts to pay for such coverage and long-term care coverage, while permitting States to continue coverage as provided under PPACA.

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

SEC. 2. DEFINITIONS.

Except as otherwise provided, in this Act:

(1) BASIC HEALTH INSURANCE.—The term ''basic health insurance'' is defined in section 122(a).

(2) DEFAULT HEALTH INSURANCE COVERAGE.—The term ''default health insurance coverage'' is defined in section 121(b)(4)(B).

(3) EXCHANGE.—The term ''Exchange'' means an Exchange established under title I of PPACA.

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

(5) LIMITED BENEFIT INSURANCE.—The term ''limited benefit insurance'' is defined in section 122(b).

(6) PPACA.—The term ''PPACA'' means the Patient Protection and Affordable Care Act (Public Law 111–148).

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

(8) STATE.—The term ''State'' includes the District of Columbia, Puerto Rico, the United States Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands.

TITLE I—REVISIONS OF PPACA

Subtitle A—Elimination of Individual and Employer Mandates

SEC. 101. REPEAL OF INDIVIDUAL HEALTH INSURANCE MANDATE.

Section 5000A of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

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

SEC. 102. REPEAL OF EMPLOYER HEALTH INSURANCE MANDATE.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended—

(1) by striking section 4980H; and

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

(b) REPEAL OF RELATED REPORTING REQUIREMENTS.—Subpart D of part III of subchapter A of chapter 61 of such Code is amended by striking section 6056 and by striking the item relating to section 6056 in the table of sections for such subpart.

(c) CONFORMING AMENDMENTS.—

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

(A) by inserting ''or'' at the end of clause (xxiii);

(B) by striking '', or'' at the end of clause (xxiv) and inserting a period; and

(C) by striking clause (xxv).

(2) Section 6724(d)(2) of such Code is amended by inserting ''or'' at the end of subparagraph (FF), by striking '', or'' at the end of subparagraph (GG) and inserting a period, and by striking subparagraph (HH).

(3) Section 1513 of the Patient Protection and Affordable Care Act is amended by striking subsection (c).

(d) EFFECTIVE DATES.—

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

(2) REPEAL OF STUDY AND REPORT.—The amendment made by subsection (c)(3) shall take effect on the date of the enactment of this Act.

SEC. 103. CLARIFYING EMPLOYER'S ABILITY TO REIMBURSE EMPLOYEE PREMIUMS FOR PURCHASE OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

An employer health care arrangement, such as a health or medical reimbursement arrangement (HRA) or other employment plans, under which an employer reimburses an employee for the premiums for the purchase of individual health insurance coverage does not constitute a group health plan for any purposes, including for purposes of applying any of the following:

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

(2) The Patient Protection and Affordable Care Act.

(3) The Internal Revenue Code of 1986.

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

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

(6) The Health Insurance Portability and Accountability Act of 1996.

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

300bb–1 et seq.), section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.).

Subtitle B—Limitation on Application of PPACA Plan Requirements

SEC. 121. LIMITING APPLICATION OF REQUIREMENTS TO CONSUMER PROTECTIONS.

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

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

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

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

(A) NO LIFETIME OR ANNUAL LIMITS.—Section 2711 (42 U.S.C. 300gg–11; relating to no lifetime or annual limits), except in the case of limited benefit insurance (as defined in section 122(b)).

(B) DEPENDENT COVERAGE THROUGH AGE 26.—Section 2714 (42 U.S.C. 300bb–14; relating to extension of dependent coverage).

(C) MODIFIED GUARANTEED AVAILABILITY.—Section 2702 (42 U.S.C. 300gg–1; relating to guaranteed availability of coverage), subject to paragraph (3) and subsection (c).

(D) GUARANTEED RENEWABILITY.—Section 2703 (42 U.S.C. 300gg–2; relating to guaranteed renewability of coverage).

(E) PROHIBITING PRE-EXISTING CONDITION EXCLUSIONS.—Section 2704 (42 U.S.C. 300gg–3; relating to prohibition on preexisting conditions).

(F) PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS.—Section 2705 (42 U.S.C. 300gg–4; relating to prohibiting discrimination

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

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

(3) APPLICATION OF A LATE ENROLLMENT PENALTY FOR THOSE WITHOUT CONTINUOUS COVERAGE.—

(A) IN GENERAL.—In the case of an individual who seeks to enroll in health insurance coverage and who, as of the effective date of such enrollment, does not have a continuous period of at least 12 months of creditable coverage, there shall be imposed a late enrollment penalty in the form of an increase in the monthly premiums for coverage of under the plan of 20 percent of the monthly premium otherwise determined for each consecutive full 12-month period (ending before such effective date) in which the individual was not enrolled in creditable coverage. Such increase shall apply during a period, to be specified under regulations of the Secretary but in no case longer than 3 times the length of the most recent pe-

riod in which the individual did not have continuous coverage.

(B) STATE WAIVER.—A State may apply to the Secretary for a waiver of the provisions of subparagraph (A) and the application of alternative provisions providing incentives for State residents to enroll in creditable coverage and maintain continuous creditable coverage. The Secretary shall approve such waiver if the Secretary determines that the alternative provisions provide similar or greater incentives for such enrollment than the incentives otherwise applicable.

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

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

come Security Act of 1974 (29 U.S.C. 1181 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 (42 U.S.C. 300gg–11 et seq.) and subpart B of part 7 of subtitle B of title I of the Employee Retirement and Income Security Act of 1974 (29 U.S.C. 1181 et seq.);

(II) also 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 (42 U.S.C. 300gg–15 et seq.).

(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 (42 U.S.C. 300gg et seq.) and subpart A of part 7 of subtitle B of title I of the Employee Retirement and Income Security Act of 1974 (29 U.S.C. 1181 et seq.);

(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 (42 U.S.C. 300gg–41 et seq.).

(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 consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish such rules as may be necessary to carry out this subparagraph.

(5) CONFORMING AMENDMENTS.—

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

(i) in subsection (a), by striking ''subsection (b)'' and inserting ''subsections (b) and (c)''; and

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

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

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

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

(i) in subsection (a), by striking ''subsection (b)'' and inserting ''subsections (b) and (c)''; and

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

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

(b) STATE FLEXIBILITY IN ENSURING ORDERLY HEALTH INSURANCE MARKET OUTSIDE OF AN EXCHANGE.—

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

rollment periods, imposing delays in the effectiveness for coverage, permitting differentials in premiums based on age and other factors, as the State determines necessary in order to ensure an orderly market for health insurance coverage in the State that is not offered through an Exchange. Such steps may include the establishment of such initial open enrollment period during which qualified residents may enroll in health insurance coverage without the imposition of any underwriting as the State determines to be appropriate in ensuring initial access to such coverage.

(2) FLEXIBILITY IN IMPOSING ADDITIONAL REQUIREMENTS.—Subject to paragraph (5), nothing in this section shall be construed as preventing a State from continuing to apply, to health insurance coverage issued in the State, requirements under the provisions of title XXVII of the Public Health Service Act (as amended by subtitles A and C of title I of PPACA) that are not continued under subsection (a).

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

Exchange in such State, as the State determines appropriate in order for the State to implement and administer a market-based system for the availability of health insurance coverage throughout the State.

(4) STATE DEFAULT ENROLLMENT OPTION.—

(A) ENROLLMENT, SUBJECT TO INDIVIDUAL 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 premiums from a health savings account under section 223 of such Code (such as age-related premiums and limitation on imposition of preexisting condition exclusions);

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

(iv) provides for coverage of childhood immunizations without cost sharing requirements to the extent such immunizations have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease

Control and Prevention with respect to the individual involved; and

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

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

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

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

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

(c) INAPPLICABILITY OF REQUIRED ESSENTIAL HEALTH BENEFITS.—

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

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

(d) EFFECTIVE DATE; TRANSITION.—

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

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

insurance issuer for portions of plans years occurring in months beginning more than 30 days after the date of the enactment of this Act.

(e) SECRETARIAL GUIDANCE.—The Secretary of Health and Human Services, in coordination with the Secretary of Labor and the Secretary of the Treasury, shall provide such guidance as may be necessary for the coordinated implementation of this section on a timely basis.

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

(1) IN GENERAL.—In the case of an individual who is covered under health insurance coverage or as a beneficiary or participant in a group health plan (as such terms are defined in section 2791 of the Public Health Service Act, 42 U.S.C. 300gg–91), if such coverage is ended and the individual obtains other health insurance coverage, group health plan coverage, or other creditable coverage (as defined for purposes of title XXVII of such Act), the issuer of the prior coverage or administrator of the prior plan shall forward information respecting such prior coverage to the issuer of the new coverage or administrator of the new plan or coverage, as the case may be, subject to such rules as the Secretary establishes

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

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

(g) APPLICATION OF RISK ADJUSTMENT.—

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

(2) FORM AND DESIGN OF RISK ADJUSTMENT MECHANISM.—The Secretary shall, in consultation with the National Association of Insurance Commissioners and other interested parties, develop a mechanism to permit the adjustment of risk among health insurance coverage offered in the individual market throughout the 50 States and the District of

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

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

(4) DEVELOPMENT OF FURTHER RISK ADJUSTMENT MECHANISM.—The Secretary shall request the National Association of Insurance Commissioners to develop a permanent model for adjustment of risk among health insurance issuers with respect to health insurance coverage offered in the individual market, with the intention that such a model would substitute for the mechanism developed under paragraph (2).

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

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

SEC. 122. OFFERING OF BASIC HEALTH INSURANCE; PROTECTION OF ASSETS FROM LIABILITY OR ATTACHMENT OR SEIZURE.

(a) REQUIREMENT FOR EXCHANGES.—

(1) IN GENERAL.—No tax credit shall be allowable under section 36B or 36C of the Internal Revenue Code of 1986 for residents of a State unless any Exchange established in the State provides for the offering of basic health insurance in all areas of the State.

(2) BASIC HEALTH INSURANCE DEFINED.—In this subsection, the term ''basic health insurance'' means, with respect to a State, such health insurance coverage as the State may specify and includes limited benefit insurance (as defined in subsection (b)).

(b) LIMITED BENEFIT INSURANCE DEFINED.—

(1) IN GENERAL.—In this title, the term ''limited benefit insurance'' means individual health insurance coverage that, with respect to a plan year, imposes (consistent with paragraph (2)) an annual

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

(2) SPECIFICATION OF ANNUAL LIMIT; VARIATION IN LIMIT FOR INDIVIDUAL AND FAMILY COVERAGE.—The Secretary shall specify, from year to year, the annual limit (or range of annual limits) that may be applied under paragraph (1). Such a limit may distinguish between coverage that is only provided for an individual and coverage that is provided also for family members of the individual.

(c) PROTECTION OF CERTAIN ASSETS IN CASE OF INDIVIDUALS COVERED UNDER LIMITED BENEFIT INSURANCE.—

(1) IN GENERAL.—Notwithstanding any other provision of law, if an individual is covered under limited benefit insurance for a plan year and benefits under such insurance have reached the annual limit under such insurance for items and services furnished in the plan year, the individual is not liable for debt incurred and arising from the provision of subsequently furnished items and services during the plan year, regardless of whether benefits are otherwise covered for such items and services under

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

(A) the bankruptcy valuation of the individual's property at the time the debt is incurred; reduced by

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

Property in the amount so protected from liability shall be exempt and immune from attachment or seizure with respect to any judgment related to such debt.

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

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

furnish any items or services to an individual who has exhausted benefits under limited benefit insurance for a plan year without the individual (or another person on the individual's behalf) providing for such advance or guarantee of payment for such items and services as may be arranged between the health care provider and the individual.

Subtitle C—Health Insurance Tax Benefit

SEC. 131. HEALTH INSURANCE TAX BENEFIT.

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

"SEC. 36C. HEALTH INSURANCE TAX CREDIT.

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

''(b) HEALTH CREDIT AMOUNT.—For purposes of this section—

''(1) IN GENERAL.—The term 'health credit amount' means the sum of the amounts determined

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

''(2) MONTHLY CREDIT AMOUNT.—

''(A) IN GENERAL.—Subject to paragraph (4), the amount determined under this paragraph with respect to any month shall be an amount equal to the sum of—

''(i) 1/12 of $2,500 in the case of any month the first day of which the taxpayer is a qualified resident and is covered by creditable coverage (twice such amount in the case of a joint return if both spouses are so covered by creditable coverage and are qualified residents), plus

''(ii) 1/12 of an amount equal to $1,500 multiplied by the number of qualifying children (within the meaning of section 152) who are qualified residents and—

''(I) for whom the taxpayer is allowed a deduction under section 151 for the taxable year in which such month ends, and

''(II) who are covered by creditable coverage on the first day of such month.

''(B) CARRYFORWARD OF MONTHLY CREDIT AMOUNT IN CASE CREDIT AMOUNT EXCEEDS HSA CONTRIBUTIONS AND PREMIUM PAYMENTS.—In the case of any month for which the credit amount determined with respect to the taxpayer under subparagraph (A) exceeds the limitation amount determined with respect to the taxpayer for such month under paragraph (3), such excess may be carried forward to any subsequent month during the taxable year for purposes of determining the credit amount for such month under this paragraph.

''(3) MONTHLY LIMITATION.—

''(A) IN GENERAL.—The amount determined under paragraph (2) for any month of the taxpayer shall not exceed the sum of—

''(i) the amounts contributed to a health savings account of the taxpayer for such month, plus

''(ii) the premiums paid by the taxpayer for creditable coverage.

"(B) CARRYFORWARD OF MONTHLY LIMITATION IN CASE HSA CONTRIBUTIONS AND PREMIUM PAYMENTS EXCEED MONTHLY CREDIT AMOUNT.—In the case of any month for which the amount determined with respect to the taxpayer under subparagraph (A) exceeds the credit amount determined with respect to the taxpayer for such month under paragraph (2), such excess may be carried forward to any subsequent month during the taxable year for purposes of determining the limitation under subparagraph (A).

"(4) ADJUSTMENT FOR LIMITED BENEFIT INSURANCE.—In the case of a taxpayer whose only health insurance coverage for a month is limited benefit insurance (as defined in section 123(b) of the World's Greatest Healthcare Plan of 2017), the amount determined under paragraph (2) shall be decreased by such proportion as the Secretary, in consultation with the Secretary of Health and Human Services, determines appropriate, taking into account the ratio of the actuarial value of such limited benefit insurance to the average actuarial value of health insurance coverage that is not limited benefit insurance.

''(5) ADJUSTMENT FOR GEOGRAPHIC AREA AND AGE OF COVERED INDIVIDUAL.—The amount determined under paragraph (2) shall be adjusted, in a manner specified by the Secretary, in consultation with and based on data collected by the Secretary of Health and Human Services, to take into account, for a taxpayer or other covered individual of an age and residing in an area, the ratio of the average cost of typical individual health insurance coverage for an individual of such age and residing in such area to the national average cost of such typical health insurance coverage. Such adjustment shall be made in a manner so that the application of this paragraph is estimated not to change the aggregate amount of the credits allowable under this section for taxable years ending in a year.

''(c) COORDINATION WITH EMPLOYER-PROVIDED HEALTH INSURANCE TAX SUBSIDY.—

''(1) CREDIT LIMITED BY EMPLOYER-PROVIDED HEALTH INSURANCE TAX SUBSIDY.—The credit allowed 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) EMPLOYER-PROVIDED HEALTH INSURANCE TAX SUBSIDY.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'employer-provided health insurance tax subsidy' means, with respect to any taxpayer for a taxable year, the sum of—

"(i) the Federal income tax subsidy of the taxpayer for the taxable year, plus

"(ii) the Federal payroll tax subsidy of the taxpayer for the taxable year.

"(B) FEDERAL INCOME TAX SUBSIDY.—The term 'Federal income tax subsidy' means, with respect to any taxpayer for the taxable year, the excess (if any) of—

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

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

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

''(C) FEDERAL PAYROLL TAX SUBSIDY.—The term 'Federal payroll tax subsidy' means, with respect to any taxpayer for the taxable year, the excess (if any) of—

''(i) the sum of—

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

"(II) the amount of tax that would have been imposed by chapter 2 on any self-employment income of the taxpayer for such taxable year had self-employment income been determined without regard to any deduction from gross income for amounts paid for insurance which constitutes medical care for the taxpayer, the taxpayer's spouse, and any qualifying children (within the meaning of section 152) for whom the taxpayer is allowed a deduction under section 151 for the taxable year, over

"(ii) the amount of tax imposed with respect to the taxpayer during such taxable year under chapter 21 and for such taxable year under chapter 2.

"(d) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—

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

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

''(2) EXCESS ADVANCE PAYMENTS.—

''(A) IN GENERAL.—If the advance payments to a taxpayer under subsection (e)(1) for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

''(B) LIMITATION ON INCREASE.—In the case of a taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed the applicable dollar amount determined in accordance with the following table (one-half of such amount in the case of a taxpayer whose tax is determined 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.

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

''(1) ADVANCE PAYMENT PROGRAM.—

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

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

''(ii) to make advance payments of the credit allowed under this section, at the election of any such individual so eligible, directly to the health savings account of any such individual, or, as a subsidy to the cost of health insurance coverage provided to any such individual, to the health insurance issuer providing such coverage or the person that administers the plan benefits with respect to such coverage.

''(B) PROGRAM REQUIREMENTS.—Such program shall be established under rules similar to the rules of section 1412 of the Patient Protection and Affordable Care Act, as in effect on the day before the date of the enactment of this section, except that advance determinations and

advance payments shall be made on request of the individual with respect to whom the determination is to be made.

''(2) INFORMATION REQUIREMENTS.—

''(A) IN GENERAL.—Each person providing health insurance coverage which constitutes medical care, and each trustee of a health savings account, shall provide the following information to the Secretary and to the taxpayer with respect to such coverage or such account:

''(i) The total premium for the coverage without regard to the credit under this section.

''(ii) The aggregate amount of any advance payment of such credit made with respect to such coverage or to such account.

''(iii) The name, address, age, and TIN of the primary insured or account holder (as the case may be) and the name, age, and TIN of each other individual obtaining coverage under such policy of insurance.

''(iv) Any information provided to such person necessary to determine eligibility for, and the amount of, such credit.

''(v) Information necessary to determine whether a taxpayer has received excess advance payments.

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

''(3) INDEXING.—

''(A) IN GENERAL.—In the case of any calendar year beginning after 2016, each of the dollar amounts in subsection (b)(2) and in the table contained under subsection (d)(2)(B) shall be equal to such dollar amount multiplied by the ratio of—

''(i) the current dollar gross domestic product (as determined based on the third estimate of the Bureau of Economic Analysis of the Department of Commerce for the second quarter of the previous year), to

''(ii) the current dollar gross domestic product (as so determined) for the second quarter of 2015.

"(B) ROUNDING.—If the amount of any change under subparagraph (A) is not a multiple of $50, such change shall be rounded to the next lowest multiple of $50.

"(f) DEFINITIONS.—For purposes of this section—

"(1) CREDITABLE COVERAGE.—

"(A) IN GENERAL.—The term 'creditable coverage' has the meaning given such term for purposes of title XXVII of the Public Health Service Act. Such term shall not include coverage under any health plan that includes coverage for abortions (other than any abortion described in subparagraph (B)).

"(B) EXCEPTION.—The second sentence of subparagraph (A) shall not apply to an abortion—

"(i) if the pregnancy is the result of an act of rape or incest, or

"(ii) in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering phys-

ical condition caused by or arising from the pregnancy itself.

"(C) SEPARATE ABORTION COVERAGE OR PLAN ALLOWED.—

"(i) OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.—Nothing in subparagraph (A) shall be construed as prohibiting any individual from purchasing separate coverage for abortions described in such subparagraph, or a health plan that includes such abortions, so long as no credit is allowed under this section with respect to the premiums for such coverage or plan.

"(ii) OPTION TO OFFER COVERAGE OR PLAN.—Nothing in subparagraph (A) shall restrict any non-Federal health insurance issuer offering a health plan from offering separate coverage for abortions described in such subparagraph, or a plan that includes such abortions, so long as premiums for such separate coverage or plan are not paid for with any amount attributable to the credit allowed under this section (or the amount of any advance payment of the credit).

''(2) QUALIFIED RESIDENT.—The term 'qualified resident' means an individual who is a citizen or national of the United States or otherwise lawfully residing in the United States under color of law.''.

(b) DISQUALIFICATION FROM EXCHANGE PLAN SUBSIDIES FOR INDIVIDUAL ONCE THEY ELECT TAX BENEFITS.—Section 36B(c)(1) of such Code is amended by adding at the end the following new subparagraph:

''(E) DENIAL OF CREDIT FOR THOSE ELECTING UNIVERSAL CREDIT.—In the case of an individual who is allowed a credit under section 36C for any taxable year, no credit shall be allowed under this section to such individual for such taxable year or any subsequent taxable year.''.

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

(1) to assist employees and employers in adjusting Federal income tax withholding to take into account the health insurance tax credit under section 36C of the Internal Revenue Code of 1986 (and any advance payment thereof), and

(2) to require employers to report to each employee with respect to periods not longer than quarterly the employer-provided health insurance tax

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

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

"Sec. 36C. Health insurance tax credit.".

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

SEC. 132. APPLICATION OF PORTION OF UNUSED TAX CREDITS BY STATES FOR INDIGENT HEALTH CARE.

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

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

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

that the year by qualified residents of such State; and

(3) 25 percent of the amount by which—

(A) the amount determined under paragraph (1) with respect to qualified residents of the State for such year; exceeds

(B) the amount determined under paragraph (2) for such State for that year.

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

(c) GRANTS TO STATES FOR INDIGENT ASSISTANCE.—

(1) APPLICATION.—A State may file with the Secretary (in a form and manner specified by the Secretary) an application to provide assistance in furnishing health services to indigent individuals residing in the State. Such application shall demonstrate the manner in which such assistance is fur-

nished 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 estimated before the beginning of the year. Payments under this section to a State for a year shall be

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

(2) RECONCILIATION BASED ON FINAL CALCULATION.—The calculations under subsection (a) for a year shall also be made after the end of the year. Insofar as the amount calculated under this paragraph for subsection (a)(3) for a State for a year exceeds (or is less than) by a material amount from the amount for subsection (a)(3) estimated and applied for the State and year under paragraph (1), the amount calculated under subsection (a)(3) for the State for the 2nd year beginning after such year, shall be reduced or increased, respectively by the amount of such excess or deficit.

SEC. 133. MEDICAID OPTION OF ENROLLMENT UNDER PRIVATE PLAN AND CONTRIBUTION TO AN HSA.

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

Code of 1986, but only if the State provides for the individual medical assistance, in the form of a deposit into a health savings account for the individual, an amount equivalent to the amount by which the amount of tax credit for the individual under such section exceeds the cost of coverage of the individual under the plan.

(b) FFP TREATMENT.—The payments by a State described in subsection (a) for coverage under a health plan and for deposit into a health savings account shall be treated as medical assistance for purposes of section 1903 of the Social Security Act (42 U.S.C. 1396b) and subject to Federal financial participating, including the application of State matching payments, in the same manner as other medical assistance furnished under title XIX of such Act, except that such amount shall be reduced by the amount of .any health insurance credits provided under section 36C of the Internal Revenue Code of 1986 with respect to such coverage or deposit.

SEC. 134. REPEAL OF THE TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS AND RELATED REPORTING REQUIREMENTS.

(a) EXCISE TAX.—Chapter 43 of the Internal Revenue Code of 1986 is amended by striking section 4980I.

(b) REPORTING REQUIREMENT.—Section 6051(a) of such Code is amended by inserting ''and'' at the end of paragraph (12), by striking '', and'' at the end of paragraph (13) and inserting a period, and by striking paragraph (14).

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

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided by paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2019.

(2) REPORTING REQUIREMENT.—The amendment made by subsection (b) shall apply to calendar years beginning after December 31, 2016.

TITLE II—IMPROVING HEALTH SAVINGS ACCOUNTS TO PROMOTE ACCOUNTABILITY

SEC. 201. TRANSITION TO NON-DEDUCTIBLE HSAS.

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

''PART IX—HEALTH SAVINGS ACCOUNTS

''Sec. 530A. Roth HSAs.

"SEC. 530A. ROTH HSAS.

"(a) IN GENERAL.—A Roth HSA shall be exempt from taxation under this subtitle. Notwithstanding the preceding sentence, the Roth HSA shall be subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable organizations). No deduction shall be allowed for any contribution to a Roth HSA.

"(b) DOLLAR LIMITATION.—

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

"(2) MONTHLY LIMITATION.—The monthly limitation for any month is 1/12 of—

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

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

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

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

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

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

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

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

shall not be allowed as a deduction under subsection (a)).

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

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

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

''(B) the limitation under paragraph (1) (after the application of subparagraph (A) and without regard to any additional contribution amount under paragraph (3))—

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

''(ii) after such reduction, shall be divided equally between them unless they agree on a different division.

''(6) DENIAL OF DEDUCTION TO DEPENDENTS.—No contribution may be made to a Roth HSA under this section by any individual with re-

spect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

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

''(8) INCREASE IN LIMIT FOR INDIVIDUALS BECOMING ELIGIBLE INDIVIDUALS AFTER THE BEGINNING OF THE YEAR.—

''(A) IN GENERAL.—For purposes of computing the limitation under paragraph (1) for any taxable year, an individual who is an eligible 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 de-

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

"(B) FAILURE TO MAINTAIN CREDITABLE COVERAGE.—

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

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

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

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

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

''(iii) TESTING PERIOD.—The term 'testing period' means the period beginning with the last month of the taxable year referred to in subparagraph (A) and ending on the last day of the 12th month following such month.

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

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

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

''(i) unless it is in cash, or

''(ii) to the extent such contribution, when added to previous contributions to

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

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

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

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

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

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

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

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

"(A) IN GENERAL.—The term 'qualified medical expenses' means, with respect to an ac-

count beneficiary, amounts paid by such beneficiary for medical care (as defined in section 213(d) as in effect on the day before the date of the enactment of the World's Greatest Healthcare Plan of 2017) for such individual, the spouse of such individual, and any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

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

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

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

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

''(iii) a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law, or

''(iv) in the case of an account beneficiary who has attained the age specified in section 1811 of the Social Security Act, any health insurance other than a medicare supplemental policy (as defined in section 1882 of the Social Security Act).

''(3) ACCOUNT BENEFICIARY.—The term 'account beneficiary' means the individual on whose behalf the Roth HSA was established.

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

''(A) Section 219(f)(3) (relating to time when contributions deemed made).

''(B) Except as provided in section 106(d), section 219(f)(5) (relating to employer payments).

''(C) Section 408(g) (relating to community property laws).

''(D) Section 408(h) (relating to custodial accounts).

''(d) ELIGIBLE INDIVIDUAL; CREDITABLE COVERAGE.—For purposes of this section—

''(1) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means, with respect to any month, any individual if such individual is covered under creditable coverage as of the first day of such month.

''(2) CREDITABLE COVERAGE.—The term 'creditable coverage' shall have the meaning given such term in section 36C(f).

''(e) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a Roth HSA which is used exclusively to pay qualified medical expenses of any account beneficiary shall not be includible in gross income.

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

''(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—

''(A) IN GENERAL.—If any excess contribution is contributed for a taxable year to

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

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

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

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

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

''(4) ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The tax imposed by this chapter on the account beneficiary for any taxable year in which there is a payment or distribution from a Roth HSA of such beneficiary which is includible in gross income under paragraph (2) shall be increased by 10 percent of the amount which is so includible.

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

''(C) EXCEPTION FOR DISTRIBUTIONS AFTER MEDICARE ELIGIBILITY.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains the age specified in section 1811 of the Social Security Act.

''(5) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

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

"(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a health savings account or a Roth HSA if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a health savings account or Roth HSA which was not includible in the individual's gross income because of the application of this paragraph.

"(6) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in a Roth HSA to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) shall

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

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

''(f) COST-OF-LIVING ADJUSTMENT.—

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

''(A) such dollar amount, multiplied by

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

''(i) by substituting 'calendar year 2015' for 'calendar year 1992' in subparagraph (B) thereof, and

''(ii) by substituting 'CPI medical care component' for 'CPI'.

''(2) CPI MEDICAL CARE COMPONENT.—For purposes of this paragraph, the term 'CPI medical care component' means the medical care component for the Consumer Price Index for All Urban Consumers published by the Department of Labor.

''(3) ROUNDING.—If the amount of any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

''(g) REPORTS.—The Secretary may require—

''(1) the trustee of a Roth HSA to make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, the return of excess contributions, and such other matters as the Secretary determines appropriate, and

''(2) any person who provides an individual with creditable coverage to make such reports to the Secretary and to the account beneficiary with respect to such plan as the Secretary determines appropriate.

The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.''.

(b) LIMIT ON CONTRIBUTIONS TO DEDUCTIBLE HEALTH SAVINGS ACCOUNTS.—Section 223 of such Code is amended by adding at the end the following new subsection:

"(i) LIMITED CONTRIBUTIONS AFTER 2016.—

"(1) IN GENERAL.—No contribution may be accepted by a health savings account after December 31, 2016.

"(2) EXCEPTIONS.—Paragraph (1) shall not apply—

"(A) in the case of a rollover contribution described in subsection (f)(5) or section 220(f)(5), or

"(B) in the case of a month for which an individual is covered by insurance that constitutes medical care and that is provided by an employer with respect to which an election is in effect for such month under section 131(b) of the World's Greatest Healthcare Plan of 2017.".

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

"PART IX. ROTH HEALTH SAVINGS ACCOUNTS".

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

SEC. 202. ELIMINATION OF MEDICAL EXPENSE DEDUCTION.

Section 213 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

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

SEC. 203. TREATMENT OF HSA AFTER DEATH OF ACCOUNT BENEFICIARY.

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

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

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

SEC. 204. TREATMENT OF CONCIERGE MEDICINE.

(a) HSAs.—

(1) ROTH HSA.—Section 530A(c)(2)(A) of the Internal Revenue Code of 1986, as added by section 201(a) of this Act, is amended by adding at the end the following: ''Such term shall include the payment of a monthly or other prepaid amount for the furnishing (or access to the furnishing) by a physician or group of physicians of physician professional services (and ancillary services).''.

(2) HSA.—Section 223(d)(2)(A) of such Code is amended by adding at the end the following: ''Such term shall include the payment of a monthly or other prepaid amount for the furnishing (or access to the furnishing) by a physician or group of physicians of physician professional services (and ancillary services).''.

(b) NOT TREATED AS HEALTH INSURANCE COVERAGE.—

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

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

(2) CONCIERGE MEDICINE DEFINED.—In this subsection, the term ''concierge medicine'' means the furnishing (or access to the furnishing) by a physician or group of physicians of physician professional services (and ancillary services) in return for payment of a monthly or other prepaid amount.

TITLE III—STATE FLEXIBILITY IN REGULATION OF HEALTH INSURANCE COVERAGE

SEC. 301. STATE FLEXIBILITY IN REGULATION OF HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—States are given the flexibility under section 122(b) to revise their regulations of the health insurance marketplace, without regard to many of the requirements imposed under PPACA, in order to promote freedom of choice of affordable health insurance coverage options offered outside of an Exchange.

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

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

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

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

TITLE IV—MEDICAID PAYMENT REFORM

SEC. 401. MEDICAID PAYMENT REFORM.

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

"SEC. 1903A. REFORMED PAYMENT TO STATES.

''(a) REFORMED PAYMENT SYSTEM.—

''(1) IN GENERAL.—For quarters beginning on or after the implementation date (as defined in subsection (k)(1)), in lieu of amounts otherwise payable to a State under this title (including any payments 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 BENEFICIARY-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

"(ii) the ratio of—

"(I) the State percentage described in subparagraph (D)(ii) for such State and fiscal year; to

"(II) the Federal percentage described in subparagraph (D)(i) for such State and fiscal year.

"(C) NONPAYMENT FOR FAILURE TO PAY STATE SHARE.—

"(i) IN GENERAL.—If a State fails to expend the amount required under subparagraph (A) for a quarter in a fiscal year, the amount payable to the State under paragraph (1) shall be reduced by the product of the amount by which the State payment is less than the State share and the ratio of—

"(I) the Federal percentage described in subparagraph (D)(i) for such State and fiscal year; to

"(II) the State percentage described in subparagraph (D)(ii) for such State and fiscal year.

"(ii) GRACE PERIOD.—A State shall not be considered to have failed to provide payment of its required State share for a quarter under subparagraph (A) if the aggregate State payment towards the State's required State share for the 4-quarter pe-

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

"(D) FEDERAL AND STATE PERCENTAGES.—In this paragraph, with respect to a State and a fiscal year:

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

"(ii) STATE PERCENTAGE.—The State percentage described in this clause is 100 percent minus the Federal percentage described in clause (i).

"(E) RULES FOR CREDITING TOWARD STATE SHARE.—

"(i) GENERAL LIMITATION TO MATCHABLE EXPENDITURES.—A payment for expenditures shall not be counted toward the State share under subparagraph (A) unless Federal payments may be used for such expenditures consistent with paragraph (3)(B).

"(ii) FURTHER LIMITATIONS ON ALLOWABLE EXPENDITURES.—A payment for expenditures shall not be counted towards the State share under subparagraph (A) if the expenditure is for any of the following:

"(I) ABORTION.—Expenditures for an abortion.

"(II) INTERGOVERNMENTAL TRANSFERS.—An expenditure that is attributable to an intergovernmental transfer.

"(III) CERTIFIED PUBLIC EXPENDITURES.—An expenditure that is attributable to certified public expenditures.

"(iii) CREDITING FRAUD AND ABUSE RECOVERIES.—Amounts recovered by a State through the operation of its Medicaid fraud and abuse control unit described in section 1903(q) shall be fully counted toward the State share under subparagraph (A).

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

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

''(G) DETERMINATION BASED UPON SUBMITTED CLAIMS.—In applying this paragraph with respect to expenditures of a State for a quarter, the determination of the expenditures for such State for such quarter shall be made after the end of the period (which, as of the date of the enactment of this section, is 2 years) for which the Secretary accepts claims for payment under this title with respect to such quarter.

''(3) USE OF FEDERAL PAYMENTS.—

''(A) APPLICATION OF MEDICAID LIMITATIONS.—A State may only use Federal payments received under subsection (a) for expenditures for which Federal funds would have been payable under this title but for this section.

''(B) LIMITATION FOR CERTAIN ELIGIBLES.—

''(i) APPLICATION OF 100 PERCENT FEDERAL POVERTY LINE LIMIT ON ELIGIBILITY.—Subject to clause (iii), a State may not use such Federal payments to provide medical assistance for an indi-

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

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

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

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

tion 1902(e)(14) (relating to a 5 percent reduction) shall not apply.

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

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

''(II) a child who is an individual described in clause (i) of section 1905(a);

''(III) enrolled in a State plan under this title as of the date of the enactment of this section for the period of continuous enrollment; or

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

''(iv) CLARIFICATION RELATED TO COMMUNITY SPOUSE.—Nothing in this subparagraph shall supersede the application of section 1924 (related to community spouse income and assets).

''(4) EXCEPTIONS FOR PASS-THROUGH PAYMENTS.—

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

payable under this title (and not under subsection (a)), 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 assistance attributable to payments to employers

for employer-sponsored health benefits coverage.

''(vii) OTHER POPULATIONS WITH LIMITED BENEFIT COVERAGE.—Other payments that are determined by the Secretary to be related to a specified population for which the medical assistance under this title is limited and does not include any inpatient, nursing facility, or long-term care services.

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

''(i) ADMINISTRATION OF MEDICARE PRESCRIPTION DRUG BENEFIT.—Expenditures described in section 1935(b) (relating to administration of the Medicare prescription drug benefit).

''(ii) PAYMENTS FOR HIT BONUSES.—Payments under section 1903(a)(3)(F) (relating to payments to encourage the adoption and use of certified EHR technology).

''(iii) PAYMENTS FOR DESIGN, DEVELOPMENT, AND INSTALLATION OF MMIS AND

ELIGIBILITY SYSTEMS.—Payments under subparagraphs (A)(i) and (H)(i) of section 1903(a)(3) for expenditures for design, development, and installation of the Medicaid management information systems and mechanized verification and information retrieval systems (related to eligibility).

''(5) PAYMENT OF AMOUNTS.—

''(A) IN GENERAL.—Except as the Secretary may otherwise provide, amounts shall be payable to a State under subsection (a) in the same manner as amounts are payable under subsection (d) of section 1903 to a State under subsection (a) of such section.

''(B) INFORMATION AND FORMS.—

''(i) SUBMISSION.—As a condition of receiving payment under subsection (a), a State shall submit such information, in such form, and manner, as the Secretary shall specify, including information necessary to make the computations under subsections (c)(2)(C) and (e).

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

reporting of such information across States.

''(C) REQUIRED REPORTING OF INFORMATION ON MEDICAL LOSS RATIOS FOR MANAGED CARE.—The information required to be reported under subparagraph (B)(i) shall include information on the medical loss ratio with respect to coverage provided under each Medicaid managed care plan with a contract with the State under section 1903(m) or 1932.

''(b) AGGREGATE BENEFICIARY-BASED AMOUNT.—

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

''(A) BENEFICIARY-BASED QUARTERLY AMOUNT.—The beneficiary-based quarterly amount for such category computed under subsection (c) for such State for such quarter.

''(B) NUMBER OF INDIVIDUALS IN CATEGORY.—Subject to subsection (d), the average number of Medicaid beneficiaries enrolled in such category in the State in such quarter.

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

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

''(B) BLIND OR DISABLED.—A category of Medicaid beneficiaries not described in subparagraph (A) who are described in section 1937(a)(2)(B)(ii).

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

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

''(c) COMPUTATION OF PER BENEFICIARY, PER CATEGORY QUARTERLY AMOUNT.—

''(1) IN GENERAL.—For a State, for each category of beneficiary for a quarter—

''(A) FIRST REFORM YEAR.—For quarters in the first reform year (as defined in subsection (k)(2)), the beneficiary-based quarterly amount is equal to ¼ of the base average per 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 year is equal to the beneficiary-based quarterly

amount under this paragraph for such State and category for the previous reform year increased by the per beneficiary percentage increase (as defined in subparagraph (E)) for such category and reform year.

''(C) FOURTH THROUGH TENTH REFORM YEARS.—The beneficiary-based quarterly amount for a State for a category for quarters in a reform year beginning with the fourth reform year and ending with the tenth reform year is—

''(i) in the case of a State that is a high per beneficiary State or a low per beneficiary State (as defined in paragraph (4)(B)(iii)) for the category, the amount determined under clause (i) or (ii) of paragraph (4)(B) for such State, category, and reform year; or

''(ii) in the case of any other State, the beneficiary-based quarterly amount under this paragraph for such State and category for the previous reform year increased by the per beneficiary percentage increase for such category and reform year.

''(D) ELEVENTH REFORM YEAR AND SUBSEQUENT REFORM YEARS.—The beneficiary-based quarterly amount for a State for a category for quarters in a reform year beginning with the eleventh reform year is equal to the beneficiary-based quarterly amount under this paragraph for such State and category for the previous reform year increased by the per beneficiary percentage increase for such category and reform year.

''(E) ANNUAL PERCENTAGE INCREASE BEGINNING WITH SECOND REFORM YEAR.—For purposes of this subsection, the term 'per beneficiary percentage increase' means, for a reform year, the sum of—

''(i) the projected percentage change in nominal gross domestic product from the midpoint of the previous reform year to the midpoint of the reform year for which the percentage increase is being applied; and

''(ii) one percentage point.

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

''(A) AVERAGE PER CATEGORY.—

"(i) IN GENERAL.—The Secretary shall determine, consistent with this paragraph and paragraph (3), a base per beneficiary, per category amount for each of the 50 States and the District of Columbia equal to the average amount, per Medicaid beneficiary, of Federal payments under this title, including payments attributable to disproportionate share hospital payments under section 1923, for each of the categories of beneficiaries under subsection (b)(2) for the base fiscal year for each of the 50 States and the District of Columbia.

"(ii) BEST AVAILABLE DATA.—The determination under clause (i) shall initially be estimated by the Secretary, based upon the best available data at the time the determination is made.

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

reflect changes in the amounts so determined based on such updates.

''(B) EXCLUSION OF PASS-THROUGH PAYMENTS.—In computing base per beneficiary, per category amounts under subparagraph (A)(i) the Secretary shall exclude payments described in subsection (a)(4).

''(C) STANDARDIZATION.—

''(i) IN GENERAL.—In computing each such amount, the Secretary shall standardize the amount in order to remove the variation attributable to the following:

''(I) RISK FACTORS.—Such risk factors as age, health and disability status (including high cost medical conditions), gender, institutional status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence.

''(II) GEOGRAPHIC.—Variations in costs on a county-by-county basis.

''(ii) METHOD OF STANDARDIZATION.—

"(I) CONSULTATION IN DEVELOPMENT OF RISK STANDARDIZATION.—In developing the methodology for risk standardization for purposes of clause (i)(I), the Secretary shall consult with the Medicaid and CHIP Payment and Access Commission, the Medicare Payment Advisory Commission, and the National Association of Medicaid Directors.

"(II) METHOD FOR RISK STANDARDIZATION.—In carrying out clause (i)(I), the Secretary may apply the hierarchal condition category methodology under section 1853(a)(1)(C). If the Secretary uses such methodology, the Secretary shall adjust the application of such methodology to take into account the differences in services provided under this title compared to title XVIII, such as the coverage of long term care, pregnancy, and pediatric services.

"(III) METHOD FOR GEOGRAPHIC STANDARDIZATION.—The Secretary

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

''(iii) APPLICATION ON A NATIONAL, BUDGET NEUTRAL BASIS.—The standardization under clause (i) shall be designed and implemented on a uniform national basis and shall be budget neutral so as to not result in any aggregate change in payments under subsection (a).

''(iv) RESPONSE TO NEW RISK.—Subject to clause (iii), the Secretary may adjust the standardization under clause (i) to respond promptly to new instances of communicable diseases and other public health hazards.

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

''(D) ADJUSTMENT FOR TEMPORARY FMAP INCREASES.—In computing each base per beneficiary, per category amounts under subpara-

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

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

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

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

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

"(A) among different categories of beneficiaries; and

''(B) between payments included under subsection (a)(1) and payments described in subsection (a)(4).

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

''(A) DETERMINATION OF NATIONAL AVERAGE BASE PER BENEFICIARY, PER CATEGORY AMOUNT.—Subject to subparagraph (C), the Secretary shall determine a national average base per beneficiary, per category amount equal to the average of the base per beneficiary, per category amounts for each of the 50 States and the District of Columbia determined under paragraph (2), weighted by the average number of beneficiaries in each such category and State as determined by the Secretary consistent with subsection (d) for the base fiscal year.

''(B) TRANSITION ADJUSTMENT.—

''(i) HIGH PER BENEFICIARY STATES.—In the case of a high per beneficiary State (as defined in clause (iii)(I)) for a category, the beneficiary-based quarterly 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 determined under subparagraph (A) for such category.

"(ii) LOW PER BENEFICIARY STATES.—In the case of a low per beneficiary State (as defined in clause (iii)(II)) for a category, the beneficiary-based quarterly 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 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 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 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 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, 7/8; and

''(II) for a subsequent reform year, the State-specific factor under this clause for the previous reform year minus 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 determine whether the application of this paragraph—

"(I) to the category for the reform year will result in an aggregate increase in the aggregate Federal expenditures under subsection (a); and

"(II) to all the categories for the reform year will result in a net aggregate increase in the aggregate Federal expenditures under subsection (a).

"(ii) ADJUSTMENT.—If the Secretary determines under clause (i)(II) that the application of this paragraph to all the categories for a reform year will result in a net aggregate increase in the aggregate Federal expenditures under subsection (a), the Secretary shall reduce the national average base per beneficiary, per category amount computed under subparagraph (A) for each of the categories determined under clause (i)(I) for which there will be an aggregate increase in the aggregate Federal expenditures under subsection (a) by such uniform percentage as will ensure that there is no net aggregate Federal expenditure increase described in clause (i)(II) for the reform year.

"(5) REPORTS ON PER BENEFICIARY RATES; APPEALS.—

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

"(i) the base per beneficiary, per category amounts under paragraph (2) for such State; and

"(ii) the national average base per beneficiary, per category amounts under paragraph (4)(A).

"(B) OPPORTUNITY TO APPEAL.—Not later than 3 months after the date a State receives notice of the Secretary's initial determination of such base per beneficiary, per category amounts for such State under subparagraph (A)(i), the State may file with the Secretary, in a form and manner specified by the Secretary, an appeal of such determination.

"(C) DETERMINATION ON APPEAL.—Not later than 3 months after receiving such an appeal, the Secretary shall make a final determination on such amounts for such State. If no such appeal is received for a State, the Sec-

retary's initial determination under subparagraph (A)(i) shall become final.

''(6) BASE FISCAL YEAR DEFINED.—In this section, the term 'base fiscal year' means the latest fiscal year, ending before the date of the enactment of this section, for which the Secretary determines that adequate data are available to make the computations required under this subsection.

''(d) NOT COUNTING INDIVIDUALS TO ACCOUNT FOR EXCLUDED PAYMENTS.—Under rules specified by the Secretary, individuals shall not be counted as Medicaid beneficiaries for purposes of subsection (b)(1)(B) and subsection (c)(2)(A) in proportion to the extent that such individuals are receiving medical assistance for which payments described under subsection (a)(4)(A) are made.

''(e) RISK ADJUSTMENT.—

''(1) IN GENERAL.—The amount under subsection (a)(1)(A) shall be adjusted under this subsection in an appropriate manner, specified by the Secretary and consistent with paragraph (2), to take into account—

''(A) the factors described in subsection (c)(2)(C)(i)(I) within a category of beneficiaries; and

"(B) variations in costs on a county-by-county basis for medical assistance and administrative expenses.

"(2) METHOD OF ADJUSTMENT.—

"(A) IN GENERAL.—The adjustments under paragraph (1) shall be made in a manner similar to the manner in which similar adjustments are made under subsection (c)(2)(C) and consistent with the requirements of clause (iii) of such subsection and subparagraph (B).

"(B) BIANNUAL UPDATE OF RISK ADJUSTMENT METHODOLOGY.—In applying clause (i)(I) of subsection (c)(2)(C) for purposes of subparagraph (A), the Secretary shall, in consultation with the entities described in clause (ii)(I) of such subsection, update the risk adjustment methodology applied as appropriate not less often than every 2 years.

"(f) CHRONIC CARE QUALITY BONUS PAYMENTS.—

"(1) DETERMINATION OF BONUS PAYMENTS.—If the Secretary determines that, based on the reports under paragraph (5), with respect to categories 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 performance of Medicare Advantage plans under part C of title XVIII.

''(B) TARGETS.—Using such system and data, the Secretary shall establish for each reform year the chronic care performance targets for purposes of the payments under paragraph (1). Such performance targets shall be established in consultation with States, associations representing individuals with chronic illnesses, entities providing treatment to such individuals for such chronic illnesses, and other stakeholders, including the National Association of Medicaid Directors and the National Governors Association.

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

''(A) data collected through methods such as—

''(i) the 'Healthcare Effectiveness Data and Information Set' (also known as 'HEDIS') (or an appropriate successor performance measurement tool);

''(ii) the 'Consumer Assessment of Healthcare Providers and Systems' (also known as 'CAHPS') (or an appropriate successor performance measurement tool); and

"(iii) the 'Health Outcomes Survey' (also known as 'HOS') (or an appropriate successor performance measurement tool); and

"(B) other data collected by the State.

"(5) REPORTS.—

"(A) IN GENERAL.—Each State shall collect, analyze, and report to the Secretary, at a frequency and in a manner to be established by the Secretary, data described in paragraph (4) that permit the Secretary to monitor the State's performance relative to the chronic care performance targets established under paragraph (3).

"(B) REVIEW AND VERIFICATION.—The Secretary may review the data collected by the State under subparagraph (A) to verify the State's analysis of such data with respect to the performance targets under paragraph (3).

"(6) AMOUNT OF BONUS PAYMENTS.—

"(A) IN GENERAL.—Subject to subparagraphs (B) and (C), with respect to each category of Medicaid beneficiaries, in the case of a State that the Secretary determines, based on the chronic care performance targets set under

paragraph (3) for a reform year for such category, performs—

"(i) in the top five States in such category, subject to subparagraph (C)(ii), the amount of the bonus for each quarter in the succeeding reform year shall be 10 percent of the payment amount otherwise paid to the State under subsection (a) for individuals enrolled under the plan within such category;

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

"(iii) 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 3 percent of the payment amount otherwise paid to the State under subsection (a) for individuals 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 beneficiaries exceed the limit specified in clause (ii) for the reform year.

"(ii) LIMIT.—The limit specified in this clause—

"(I) for the second reform year is equal to $250,000,000; or

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

"(C) LIMITATION AND PRORATION OF BONUSES BASED ON APPLICATION OF AGGREGATE LIMIT.—

"(i) NO BONUS FOR THIRD OR SUBSEQUENT TIERS UNLESS AGGREGATE LIMIT NOT REACHED ON FIRST TWO TIERS.—No bonus shall be payable under clause (iii), (iv), or (v) of subparagraph (A) for a category of Medicaid beneficiaries for a quarter in a reform year unless the aggregate amount of bonuses under clauses (i) and (ii) of such subparagraph for such category and reform year is less than the limit specified 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), and (v) of subparagraph (A) shall be prorated in a manner so the aggregate

amount of all the bonuses under subparagraph (A) is equal to such limit.

''(g) STATE OPTION FOR RECEIVING MEDICARE PAYMENTS FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

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

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

''(B) any items and services which such eligible individuals would otherwise receive under title XVIII.

''(2) PROVIDER PAYMENT REQUIREMENT.—

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

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

"(B) FLEXIBILITY IN PAYMENT METHODS.—Nothing in subparagraph (A) shall be construed as preventing a State from using alternative payment methodologies (such as bundled payments or the use of accountable care organizations (as such term is used in section 1899)) for purposes of making payments to health care providers for items and services provided to dual eligible individuals in the State under the option under this subsection.

"(3) PAYMENTS TO STATES IN LIEU OF MEDICARE PAYMENTS.—With respect to a full-benefit dual eligible individual, in the case of a State that elects the option under paragraph (1) for quarters in a reform year—

"(A) the Secretary shall not make any payment under title XVIII for items and services furnished to such individual for such quarters; and

"(B) the Secretary shall pay to the State, in addition to the amounts paid to such State under subsection (a), the amount that the Secretary would, but for this subsection, otherwise

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

''(4) FULL-BENEFIT DUAL ELIGIBLE INDIVIDUAL DEFINED.—In this subsection, the term 'full-benefit dual eligible individual' means an individual who meets the requirements of section 1935(c)(6)(A)(ii).

''(h) AUDITS.—The Secretary shall conduct such audits on the number and classification of Medicaid beneficiaries under such subsections and expenditures under this section as may be necessary to ensure appropriate payments under this section.

''(i) TREATMENT OF WAIVERS.—

''(1) NO IMPACT ON CURRENT WAIVERS.—In the case of a waiver of requirements of this title pursuant to section 1115 or other law that is in effect as of the date of the enactment of this section, nothing in this section shall be construed to affect such waiver for the period of the waiver as approved as of such date.

''(2) APPLICATION OF BUDGET NEUTRALITY TO SUBSEQUENT WAIVERS AND RENEWALS TAKING SECTION INTO ACCOUNT.—In the case of a waiver of requirements of this title pursuant to section 1115 or

other law that is approved or renewed after the date of the enactment of this section, to the extent that such approval or renewal is conditioned upon a demonstration of budget neutrality, budget neutrality shall be determined taking into account the application of this section.

''(j) REPORT TO CONGRESS.—Not later than January 1 of the second reform year, the Secretary shall submit to Congress a report on the implementation of this section.

''(k) DEFINITIONS.—In this section:

''(1) IMPLEMENTATION DATE.—The term 'implementation date' means—

''(A) July 1, 2018, if this section is enacted on or before July 1, 2017; or

''(B) July 1, 2019, if this section is enacted after July 1, 2017.

''(2) REFORM YEARS.—

''(A) The term 'reform year' means a fiscal year beginning with the first reform year.

''(B) The term 'first reform year' means the fiscal year in which the implementation date occurs.

''(C) The terms 'second', 'third', and successive similar terms mean, with respect to a reform year, the second, third, or successive re-

form 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 the Social Security 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 ''subsections (a) and (b)'';

(ii) in paragraph (2)—

(I) in subparagraph (A), by inserting ''or section 1903A'' after ''was made under this section''; and

(II) in subparagraph (B), by inserting ''or section 1903A'' after ''under subsection (a)'';

(iii) in paragraph (4)—

(I) by striking ''under this subsection'' and inserting '', with respect to this section or section 1903A, under this subsection''; and

(II) by striking ''under this section'' and inserting ''under the respective 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''.

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

retary of Health and Human Services shall submit to Congress a report that includes a description of any additional technical and conforming amendments to law that are required to properly carry out this Act.

TITLE V—INCREASING PRICE TRANSPARENCY AND FREEDOM OF PRACTICE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the case of an individual entitled to benefits under part A and enrolled under part B.

''(2) SPECIAL RULE FOR ITEMS AND SERVICES FURNISHED AS A BUNDLE.—In the case of items and services for which there is a single price for a group or bundle of such items and services, the maximum charge permitted under paragraph (1) may not exceed the lesser of—

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

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

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

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

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

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

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

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

"(i) to establish a single price for related items and services in a manner similar to the manner in which pricing and payment for such items and services is provided under the Medicare program under title XVIII of the Social Security Act, and

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

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

health care provider shall be treated as not meeting the requirement of subparagraph (A), in the case of items and services for which the provider is disclosing a cash price, if the provider—

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

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

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

"(E) Section 223(f) (relating to cash price transparency required for payments to health care providers).".

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

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

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

SEC. 503. LIBERATING THE LOCAL PRACTICE OF HEALTH CARE.

(a) WAIVING NATIONAL RESTRICTIONS ON PHYSICIAN-OWNED FACILITIES.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended by adding at the end the following new subsection:

''(j) WAIVER AUTHORITY.—A physician or other entity may apply to the Secretary to waive any provision of this section and the Secretary may waive such provision with respect to such physician or entity if the Secretary determines that such waiver would—

''(1) increase competition within the health care market;

''(2) reduce the costs of health care; and

''(3) increase the quality of health care.''.

(b) REMOVING CERTAIN STATE AND LOCAL LICENSURE OR CERTIFICATION RESTRICTIONS.—

(1) APPLICATION FOR WAIVER OF RESTRICTIONS.—An individual who is required to be licensed or certified by a State as a condition of furnishing

items or services as a health care professional (as defined by the Secretary of Health and Human Services) may submit to the Secretary an application to waive any condition of such licensure or certification.

(2) STANDARD.—The Secretary may grant a waiver submitted under paragraph (1) if the Secretary determines such waiver would—

(A) increase competition within the health care market;

(B) reduce the costs of health care; and

(C) increase the quality of health care.

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

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