# [DISCUSSION DRAFT]

114TH CONGRESS
2D SESSION

# H. R. ____

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

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IN THE HOUSE OF REPRESENTATIVES

Mr. SESSIONS introduced the following bill; which was referred to the Committee on ____________________________

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# A BILL

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

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

1 **SECTION 1. SHORT TITLE; PURPOSES; TABLE OF CON-**
2 **TENTS.**
3 (a) SHORT TITLE.—This Act may be cited as the
4 "Healthcare Accessibility, Empowerment, and Liberty Act
5 of 2016".
6 (b) PURPOSES.—The purposes of this Act are as fol-
7 lows:
8 (1) ELIMINATION OF INDIVIDUAL AND EM-
9 PLOYER MANDATES UNDER ACA.—To eliminate man-
10 dates on individuals and employers, and other tax
11 requirements, imposed under Patient Protection and
12 Affordable Care Act.
13 (2) PROVIDING STATES WITH ALTERNATIVE,
14 AFFORDABLE COVERAGE OPTIONS.—To provide
15 greater flexibility in providing States with options in
16 making affordable health insurance coverage avail-
17 able by eliminating certain mandates under PPACA,
18 while retaining essential consumer protections, by
19 promoting health savings accounts to pay for such
20 coverage and long-term care coverage, while permit-
21 ting States to continue coverage as provided under
22 PPACA.
23 (c) TABLE OF CONTENTS.—The table of contents of
24 this Act is as follows:

Sec. 1. Short title; purposes; table of contents.
Sec. 2. Definitions.

TITLE I—REVISIONS OF PPACA

Subtitle A—Elimination of Individual and Employer Mandates

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

Subtitle B—Limitation on Application of PPACA Plan Requirements

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

Subtitle C—Universal Health Insurance Tax Benefit

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

TITLE II—IMPROVING HEALTH SAVINGS ACCOUNTS TO PROMOTE ACCOUNTABILITY

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

TITLE III—STATE FLEXIBILITY IN REGULATION OF HEALTH INSURANCE COVERAGE

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

TITLE IV—MEDICAID PAYMENT REFORM

Sec. 401. Medicaid payment reform.

TITLE V—INCREASING PRICE TRANSPARENCY AND FREEDOM OF PRACTICE

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

1 **SEC. 2. DEFINITIONS.**

2 Except as otherwise provided, in this Act:

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

1 (2) DEFAULT HEALTH INSURANCE COV-
2 ERAGE.—The term ''default health insurance cov-
3 erage'' is defined in section 121(b)(4)(B).
4 (3) EXCHANGE.—The term ''Exchange'' means
5 an Exchange established under title I of PPACA.
6 (4) HEALTH INSURANCE COVERAGE; GROUP
7 HEALTH PLAN, ETC.—The terms defined in section
8 2791 of the Public Health Service Act, including
9 ''health insurance coverage'', ''group health plan''
10 ''individual market'', shall apply.
11 (5) LIMITED BENEFIT INSURANCE.—The term
12 ''limited benefit insurance'' is defined in section
13 122(b).
14 (6) PPACA.—The term ''PPACA'' means the
15 Patient Protection and Affordable Care Act (Public
16 Law 111–148).
17 (7) SECRETARY.—The term ''Secretary'' means
18 the Secretary of Health and Human Services.
19 (8) STATE.—The term ''State'' includes the
20 District of Columbia, Puerto Rico, the United States
21 Virgin Islands, American Samoa, Guam, and the
22 Northern Mariana Islands.

# 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 Healthcare Accessibility, Empowerment, and Liberty Act of 2016.".

### 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 ‘‘and’’ at the end of clause (xxiv) and inserting ‘‘or’’; 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 Ac, 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, section

4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974.

## 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 as in effect 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

1 health insurance coverage offered in the individual
2 and group market:
3 (A) NO LIFETIME OR ANNUAL LIMITS.—
4 Section 2711 (relating to no lifetime or annual
5 limits), except in the case of limited benefit in-
6 surance (as defined in section 122(b)).
7 (B) DEPENDENT COVERAGE THROUGH
8 AGE 26.—Section 2714 (relating to extension of
9 dependent coverage).
10 (C) MODIFIED GUARANTEED AVAIL-
11 ABILITY.—Section 2702 (relating to guaranteed
12 availability of coverage), subject to paragraph
13 (3) and subsection (c).
14 (D) GUARANTEED RENEWABILITY.—Sec-
15 tion 2703 (relating to guaranteed renewability
16 of coverage).
17 (E) PROHIBITING PRE-EXISTING CONDI-
18 TION EXCLUSIONS.—Section 2704 (relating to
19 prohibition on preexisting conditions).
20 (F) PROHIBITING DISCRIMINATION BASED
21 ON HEALTH STATUS.—Section 2705 (relating to
22 prohibiting discrimination against individual
23 participants and beneficiaries based on health
24 status), subject to subsection (c).

1 (G) NON-DISCRIMINATION IN HEALTH
2 CARE.—Section 2706 (relating to non-discrimi-
3 nation in health care).
4 (3) APPLICATION OF A LATE ENROLLMENT
5 PENALTY FOR THOSE WITHOUT CONTINUOUS COV-
6 ERAGE.—
7 (A) IN GENERAL.—In the case of an indi-
8 vidual who seeks to enroll in health insurance
9 coverage and who, as of the effective date of
10 such enrollment, does not have a continuous pe-
11 riod of at least 12 months of creditable cov-
12 erage, there shall be imposed a late enrollment
13 penalty in the form of an increase in the
14 monthly premiums for coverage of under the
15 plan of 20 percent of the monthly premium oth-
16 erwise determined for each consecutive full 12-
17 month period (ending before such effective
18 date) in which the individual was not enrolled
19 in creditable coverage. Such increase shall apply
20 during a period, to be specified under regula-
21 tions of the Secretary but in no case longer
22 than 3 times the length of the most recent pe-
23 riod in which the individual did not have contin-
24 uous coverage.

1 (B) STATE WAIVER.—A State may apply
2 to the Secretary for a waiver of the provisions
3 of subparagraph (A) and the application of al-
4 ternative provisions providing incentives for
5 State residents to enroll in creditable coverage
6 and maintain continuous creditable coverage.
7 The Secretary shall approve such waiver if the
8 Secretary determines that the alternative provi-
9 sions provide similar or greater incentives for
10 such enrollment than the incentives otherwise
11 applicable.
12 (4) COORDINATING IMPLEMENTATION OF PRE-
13 PPACA PHSA PROVISIONS WITH PPACA CONSUMER
14 PROTECTIONS.—
15 (A) IN GENERAL.—In applying this sub-
16 section, the provisions described in paragraph
17 (2) shall be treated as if they were included in
18 title XXVII of the Public Health Service Act,
19 as in effect before the date of enactment of
20 PPACA, and, with respect to group health
21 plans and health insurance coverage offered in
22 connection with such plans, in part 7 of subtitle
23 B of title I of the Employee Retirement and In-
24 come Security Act of 1974, and, with respect to

1 group health plans, in chapter 100 of the Inter-
2 nal Revenue Code of 1986 as follows:
3 (i) LIFETIME LIMITS; DEPENDENT
4 COVERAGE.—The provisions described in
5 paragraphs (2)(A) and (2)(B) shall be
6 treated as included—
7 (I) with respect to group health
8 plans (and health insurance coverage
9 offered with respect to such plans),
10 under subpart 2 of part A of title
11 XXVII of the Public Health Service
12 Act and subpart B of part 7 of sub-
13 title B of title I of the Employee Re-
14 tirement and Income Security Act of
15 1974;
16 (II) also with respect to group
17 health plans, under subchapter B of
18 chapter 100 of the Internal Revenue
19 Code of 1986; and
20 (III) with respect to individual
21 health insurance coverage, under sub-
22 part 2 of part B of title XXVII of the
23 Public Health Service Act.
24 (ii) REMAINING PROVISIONS.—The
25 provision described in paragraph (2) (other

1 than in subparagraph (A) or (B) of such
2 paragraph) shall be treated as included—
3 (I) with respect to group health
4 plans (and health insurance coverage
5 offered with respect to such plans),
6 under subpart 1 of part A of title
7 XXVII of the Public Health Service
8 Act and subpart A of part 7 of sub-
9 title B of title I of the Employee Re-
10 tirement and Income Security Act of
11 1974;
12 (II) also with respect to group
13 health plans, under subchapter A of
14 chapter 100 of the Internal Revenue
15 Code of 1986; and
16 (III) with respect to individual
17 health insurance coverage, under sub-
18 part 1 of part B of title XXVII of the
19 Public Health Service Act.
20 (B) CONFLICTING PROVISIONS.—In the
21 case described in paragraph (1) where there is
22 a conflict between a provision described in para-
23 graph (2) and a provision of law described in
24 paragraph (1), the provision described in para-
25 graph (2) shall control and the Secretary, in

1 consultation with the Secretary of the Treasury
2 and the Secretary of Labor, shall establish such
3 rules as may be necessary to carry out this sub-
4 paragraph.
5 (5) CONFORMING AMENDMENTS.—
6 (A) ERISA.—Section 715 of the Employee
7 Retirement Income Security Act of 1974 (29
8 U.S.C. 1185d) is amended—
9 (i) in subsection (a), by striking "sub-
10 section (b)" and inserting "subsections (b)
11 and (c)"; and
12 (ii) by adding at the end the following
13 new subsection:
14 "(c) ADDITIONAL EXCEPTION.—Pursuant to section
15 121 of the Healthcare Accessibility, Empowerment, and
16 Liberty Act of 2016, the provisions of part A of title
17 XXVII of the Public Health Service Act referred to in sub-
18 section (a), other than those provisions specified in section
19 121(a)(2) of the Healthcare Accessibility, Empowerment,
20 and Liberty Act of 2016, shall not apply to plans and cov-
21 erage described in subsection (a), whether or not the plans
22 or coverage are offered through an Exchange established
23 under the Patient Protection and Affordable Care Act.".
24 (B) IRC.—Section 9815 of the Internal
25 Revenue Code of 1986 is amended—

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

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

6 "(c) ADDITIONAL EXCEPTION.—Pursuant to section
7 121 of the Healthcare Accessibility, Empowerment, and
8 Liberty Act of 2016, the provisions of part A of title
9 XXVII of the Public Health Service Act referred to in sub-
10 section (a), other than those provisions specified in section
11 121(a)(2) of the Healthcare Accessibility, Empowerment,
12 and Liberty Act of 2016, shall not apply to plans described
13 in subsection (a).".

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

17 (1) IN GENERAL.—With respect to health insur-
18 ance coverage offered in a State, the State may, in
19 consultation with the Secretary, take such steps,
20 such as limiting the availability of general open en-
21 rollment periods, imposing delays in the effectiveness
22 for coverage, permitting differentials in premiums
23 based on age and other factors, as the State deter-
24 mines necessary in order to ensure an orderly mar-
25 ket for health insurance coverage in the State that

1 is not offered through an Exchange. Such steps may
2 include the establishment of such initial open enroll-
3 ment period during which qualified residents may
4 enroll in health insurance coverage without the im-
5 position of any underwriting as the State determines
6 to be appropriate in ensuring initial access to such
7 coverage.

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

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

24 (4) STATE DEFAULT ENROLLMENT OPTION.—

1 (A) ENROLLMENT, SUBJECT TO INDI-
2 VIDUAL OPT-OUT.—Subject to subparagraph
3 (D), a State may elect to provide for the enroll-
4 ment of residents of the State who are unin-
5 sured in default health insurance coverage (as
6 defined in subparagraph (B)) and establishing a
7 Roth HSA for such residents who do not have
8 a Roth HSA unless the resident has affirma-
9 tively elected not to be so enrolled and not to
10 have such an account. respectively. If a State
11 makes such an election, the State shall permit
12 eligible residents to enroll in such coverage on
13 a continuous basis.
14 (B) DEFAULT HEALTH INSURANCE COV-
15 ERAGE DEFINED.—In this paragraph, the term
16 "default health insurance coverage" means,
17 with respect to a State, health insurance cov-
18 erage that—
19 (i) is a high deductible health plan
20 (within the meaning of section 223(c)(2) of
21 the Internal Revenue Code of 1986) with
22 prescription drug coverage limited to ge-
23 neric drugs for a limited number of chronic
24 conditions (commonly referred to as tier I
25 pharmacy benefit);

1 (ii) meets such requirements as may
2 apply to qualify for the payment of plan
3 premiums from a health savings account
4 under section 223 of such Code (such as
5 age-related premiums and limitation on
6 imposition of preexisting condition exclu-
7 sions);
8 (iii) has a provider network for cov-
9 ered benefits that is adequate (as deter-
10 mined consistent with guidelines issued by
11 the Secretary) to ensure access to health
12 benefits under such plan;
13 (iv) provides for coverage of childhood
14 immunizations without cost sharing re-
15 quirements to the extent such immuniza-
16 tions have in effect a recommendation
17 from the Advisory Committee on Immuni-
18 zation Practices of the Centers for Disease
19 Control and Prevention with respect to the
20 individual involved; and
21 (v) meets such other requirements as
22 the State may specify.
23 (C) ROTH HSA.—In this paragraph, the
24 term ''Roth HSA'' shall have the meaning given

1 such term by section 530A(c) of the Internal
2 Revenue Code of 1986.

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

12 (c) INAPPLICABILITY OF REQUIRED ESSENTIAL
13 HEALTH BENEFITS.—

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

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

25 (d) EFFECTIVE DATE; TRANSITION.—

1 (1) IN GENERAL.—Subsection (a), (b), and (c)
2 shall apply to plan years beginning after the date of
3 the enactment of this Act.
4 (2) SUNSETTING REQUIRED CONTRIBUTION FOR
5 ACA REINSURANCE PROGRAM.—No contribution shall
6 be required under section 1341 of PPACA (42
7 U.S.C. 18061) from any group health plan or health
8 insurance issuer for portions of plans years occur-
9 ring in months beginning more than 30 days after
10 the date of the enactment of this Act.
11 (e) SECRETARIAL GUIDANCE.—The Secretary of
12 Health and Human Services, in coordination with the Sec-
13 retary of Labor and the Secretary of the Treasury, shall
14 provide such guidance as may be necessary for the coordi-
15 nated implementation of this section on a timely basis.
16 (f) TRANSFERRING HEALTH PLAN RECORDS UPON
17 CHANGING PLANS.—
18 (1) IN GENERAL.—In the case of an individual
19 who is covered under health insurance coverage or as
20 a beneficiary or participant in a group health plan
21 (as such terms are defined in section 2791 of the
22 Public Health Service Act), if such coverage is ended
23 and the individual obtains other health insurance
24 coverage, group health plan coverage, or other cred-
25 itable coverage (as defined for purposes of title

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

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

17 (g) APPLICATION OF RISK ADJUSTMENT.—

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

1 (2) FORM AND DESIGN OF RISK ADJUSTMENT
2 MECHANISM.—The Secretary shall, in consultation
3 with the National Association of Insurance Commis-
4 sioners and other interested parties, develop a mech-
5 anism to permit the adjustment of risk among
6 health insurance coverage offered in the individual
7 market throughout the 50 States and the District of
8 Columbia. Such mechanism shall be designed to ef-
9 fect the same type of risk adjustment among such
10 coverage that is applicable to risk adjustment of
11 payments among Medicare Advantage organizations
12 under part C of title XVIII of the Social Security
13 Act.
14 (3) TRANSITION FOR NEW COVERAGE.—The
15 mechanism developed under paragraph (2) shall pro-
16 vide for transitional protection, over a 3 year period,
17 in the case of health insurance coverage that has not
18 been previously marketed.
19 (4) DEVELOPMENT OF FURTHER RISK ADJUST-
20 MENT MECHANISM.—The Secretary shall request the
21 National Association of Insurance Commissioners to
22 develop a permanent model for adjustment of risk
23 among health insurance issuers with respect to
24 health insurance coverage offered in the individual
25 market, with the intention that such a model would

1 substitute for the mechanism developed under para-
2 graph (2).
3 (5) TREATMENT AS PLAN REQUIREMENT
4 UNDER PHSA, ERISA, IRC.—The requirement of
5 paragraph (1) shall apply as if it were a section
6 under part A of title XXVII of the Public Health
7 Service Act, including for purposes of applying sec-
8 tion 715 of the Employee Retirement Income Secu-
9 rity Act of 1976 (29 U.S.C. 1185d) and section
10 9815 of the Internal Revenue Code of
11 1986.requirement.

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

15 (a) REQUIREMENT FOR EXCHANGES.—
16 (1) IN GENERAL.—No tax credit shall be allow-
17 able under section 36B or 36C of the Internal Rev-
18 enue Code of 1986 for residents of a State unless
19 any Exchange established in the State provides for
20 the offering of basic health insurance in all areas of
21 the State.
22 (2) BASIC HEALTH INSURANCE DEFINED.—In
23 this subsection, the term ‘‘basic health insurance’’
24 means, with respect to a State, such health insur-
25 ance coverage as the State may specify and includes

1 limited benefit insurance (as defined in subsection
2 (b)).
3 (b) LIMITED BENEFIT INSURANCE DEFINED.—
4 (1) IN GENERAL.—In this title, the term ''lim-
5 ited benefit insurance'' means individual health in-
6 surance coverage that, with respect to a plan year,
7 imposes (consistent with paragraph (2)) an annual
8 limit on the amounts that may be payable under the
9 coverage with respect to expenses incurred for items
10 and services furnished in that plan year.
11 (2) SPECIFICATION OF ANNUAL LIMIT; VARI-
12 ATION IN LIMIT FOR INDIVIDUAL AND FAMILY COV-
13 ERAGE.—The Secretary shall specify, from year to
14 year, the annual limit (or range of annual limits)
15 that may be applied under paragraph (1). Such a
16 limit may distinguish between coverage that is only
17 provided for an individual and coverage that is pro-
18 vided also for family members of the individual.
19 (c) PROTECTION OF CERTAIN ASSETS IN CASE OF
20 INDIVIDUALS COVERED UNDER LIMITED BENEFIT IN-
21 SURANCE.—
22 (1) IN GENERAL.—Notwithstanding any other
23 provision of law, if an individual is covered under
24 limited benefit insurance for a plan year and bene-
25 fits under such insurance have reached the annual

1 limit under such insurance for items and services
2 furnished in the plan year, the individual is not lia-
3 ble for debt incurred and arising from the provision
4 of subsequently furnished items and services during
5 the plan year, regardless of whether benefits are oth-
6 erwise covered for such items and services under
7 such policy, insofar as the liability attributable to
8 such items and services exceeds—
9 (A) the bankruptcy valuation of the indi-
10 vidual's property at the time the debt is in-
11 curred; reduced by
12 (B) such annual limit of benefits under the
13 limited benefit insurance for the plan year.
14 Property in the amount so protected from liability
15 shall be exempt and immune from attachment or sei-
16 zure with respect to any judgment related to such
17 debt.
18 (2) BANKRUPTCY VALUATION DEFINED.—In
19 this subsection, the term ''bankruptcy valuation''
20 means, with respect to property of an individual as
21 of a date, the value of the property as of such date
22 as determined as if the individual were a debtor in
23 a bankruptcy case that could have been filed under
24 title 11 of the United States Code and the property
25 could not be exempt under section 522 of such title.

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

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

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

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

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

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

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

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

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

9 "(2) MONTHLY CREDIT AMOUNT.—

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

14 "(i) 1⁄12 of $2,500 in the case of any
15 month the first day of which the taxpayer
16 is covered by creditable coverage (twice
17 such amount in the case of a joint return
18 if both spouses are so covered by creditable
19 coverage), plus

20 "(ii) 1⁄12 of an amount equal to
21 $1,500 multiplied by the number of quali-
22 fying children (within the meaning of sec-
23 tion 152)—

24 "(I) for whom the taxpayer is al-
25 lowed a deduction under section 151

1 for the taxable year in which such
2 month ends, and
3 ‘‘(II) who are covered by cred-
4 itable coverage on the first day of
5 such month.
6 ‘‘(B) CARRYFORWARD OF MONTHLY CRED-
7 IT AMOUNT IN CASE CREDIT AMOUNT EXCEEDS
8 HSA CONTRIBUTIONS AND PREMIUM PAY-
9 MENTS.—In the case of any month for which
10 the credit amount determined with respect to
11 the taxpayer under subparagraph (A) exceeds
12 the limitation amount determined with respect
13 to the taxpayer for such month under para-
14 graph (3), such excess may be carried forward
15 to any subsequent month during the taxable
16 year for purposes of determining the credit
17 amount for such month under this paragraph.
18 ‘‘(3) MONTHLY LIMITATION.—
19 ‘‘(A) IN GENERAL.—The amount deter-
20 mined under paragraph (2) for any month of
21 the taxpayer shall not exceed the sum of—
22 ‘‘(i) the amounts contributed to a
23 health savings account of the taxpayer for
24 such month, plus

1 "(ii) the premiums paid by the tax-
2 payer for creditable coverage.
3 "(B) CARRYFORWARD OF MONTHLY LIMI-
4 TATION IN CASE HSA CONTRIBUTIONS AND PRE-
5 MIUM PAYMENTS EXCEED MONTHLY CREDIT
6 AMOUNT.—In the case of any month for which
7 the amount determined with respect to the tax-
8 payer under subparagraph (A) exceeds the cred-
9 it amount determined with respect to the tax-
10 payer for such month under paragraph (2),
11 such excess may be carried forward to any sub-
12 sequent month during the taxable year for pur-
13 poses of determining the limitation under sub-
14 paragraph (A).
15 "(4) ADJUSTMENT FOR LIMITED BENEFIT IN-
16 SURANCE.—In the case of a taxpayer whose only
17 health insurance coverage for a month is limited
18 benefit insurance (as defined in section 123(b) of the
19 Healthcare Accessibility, Empowerment, and Liberty
20 Act of 2016), the amount determined under para-
21 graph (2) shall be decreased by such proportion as
22 the Secretary, in consultation with the Secretary of
23 Health and Human Services, determines appro-
24 priate, taking into account the ratio of the actuarial
25 value of such limited benefit insurance to the aver-

1 age actuarial value of health insurance coverage that
2 is not limited benefit insurance.
3 "(5) ADJUSTMENT FOR GEOGRAPHIC AREA AND
4 AGE OF COVERED INDIVIDUAL.—The amount deter-
5 mined under paragraph (2) shall be adjusted, in a
6 manner specified by the Secretary, in consultation
7 with and based on data collected by the Secretary of
8 Health and Human Services, to take into account,
9 for a taxpayer or other covered individual of an age
10 and residing in an area, the ratio of the average cost
11 of typical individual health insurance coverage for an
12 individual of such age and residing in such area to
13 the national average cost of such typical health in-
14 surance coverage. Such adjustment shall be made in
15 a manner so that the application of this paragraph
16 is estimated not to change the aggregate amount of
17 the credits allowable under this section for taxable
18 years ending in a year.
19 "(c) COORDINATION WITH EMPLOYER-PROVIDED
20 HEALTH INSURANCE TAX SUBSIDY.—
21 "(1) CREDIT LIMITED BY EMPLOYER-PROVIDED
22 HEALTH INSURANCE TAX SUBSIDY.—The credit al-
23 lowed under this section for any taxable year shall
24 not exceed an amount equal to the excess (if any)
25 of—

1 "(A) the maximum credit which would be
2 allowed for all months of the taxpayer during
3 the taxable year (determined under subsection
4 (b)(2) and without regard to this subsection,
5 the limitation under subsection (b)(3), and any
6 reduction under subsection (d)(1)), over
7 "(B) the taxpayer's employer-provided
8 health insurance tax subsidy for the taxable
9 year.
10 "(2) RECAPTURE OF EXCESS EMPLOYER-PRO-
11 VIDED HEALTH INSURANCE TAX SUBSIDY.—In the
12 case of any taxpayer with respect to whom for any
13 taxable year the amount described in subparagraph
14 (B) of paragraph (1) exceeds the amount described
15 in subparagraph (A) of such paragraph, the credit
16 allowed under this section shall be treated as zero
17 and the tax imposed by this chapter for the taxable
18 year shall be increased by the amount of such ex-
19 cess.
20 "(3) EMPLOYER-PROVIDED HEALTH INSURANCE
21 TAX SUBSIDY.—For purposes of this subsection—
22 "(A) IN GENERAL.—The term 'employer-
23 provided health insurance tax subsidy' means,
24 with respect to any taxpayer for a taxable year,
25 the sum of—

1 "(i) the Federal income tax subsidy of
2 the taxpayer for the taxable year, plus
3 "(ii) the Federal payroll tax subsidy
4 of the taxpayer for the taxable year.
5 "(B) FEDERAL INCOME TAX SUBSIDY.—
6 The term 'Federal income tax subsidy' means,
7 with respect to any taxpayer for the taxable
8 year, the excess (if any) of—
9 "(i) the amount of tax that would
10 have been imposed by this chapter for the
11 taxable year had such tax been determined
12 without regard to this section and by in-
13 cluding amounts otherwise excluded from
14 gross income which were paid by or on be-
15 half of the taxpayer for employer-provided
16 insurance that constitutes medical care,
17 over
18 "(ii) the amount of tax imposed by
19 this chapter for the taxable year (deter-
20 mined without regard to this section).
21 "(C) FEDERAL PAYROLL TAX SUBSIDY.—
22 The term 'Federal payroll tax subsidy' means,
23 with respect to any taxpayer for the taxable
24 year, the excess (if any) of—
25 "(i) the sum of—

1 "(I) the amount of tax that
2 would have been imposed by chapter
3 21 with respect to any wages of the
4 taxpayer paid during the taxable year
5 had such tax been determined by in-
6 cluding amounts otherwise excluded
7 from wages which were paid by or on
8 behalf of the taxpayer during the tax-
9 able year for employer-provided insur-
10 ance that constitutes medical care,
11 plus
12 "(II) the amount of tax that
13 would have been imposed by chapter 2
14 on any self-employment income of the
15 taxpayer for such taxable year had
16 self-employment income been deter-
17 mined without regard to any deduc-
18 tion from gross income for amounts
19 paid for insurance which constitutes
20 medical care for the taxpayer, the tax-
21 payer's spouse, and any qualifying
22 children (within the meaning of sec-
23 tion 152) for whom the taxpayer is al-
24 lowed a deduction under section 151
25 for the taxable year, over

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

5 "(4) NO CREDIT OR RECAPTURE FOR INSUR-
6 ANCE PROVIDED BY EMPLOYER ELECTING EXCLU-
7 SION REGIME.—In the case of an individual who for
8 any month is covered by insurance that constitutes
9 medical care and that is provided by an employer
10 with respect to which an election is in effect for such
11 month under section 131(b) of the Healthcare Ac-
12 cessibility, Empowerment, and Liberty Act of
13 2016—

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

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

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

24 "(1) IN GENERAL.—The amount of the credit
25 allowed under this section for any taxable year (after

1 the application of subsections (b) and (c)) shall be
2 reduced (but not below zero) by the amount of any
3 advance payment of such credit under subsection
4 (e)(1).

5 "(2) EXCESS ADVANCE PAYMENTS.—

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

13 "(B) LIMITATION ON INCREASE.—In the
14 case of a taxpayer whose household income is
15 less than 400 percent of the poverty line for the
16 size of the family involved for the taxable year,
17 the amount of the increase under subparagraph
18 (A) shall in no event exceed the applicable dol-
19 lar amount determined in accordance with the
20 following table (one-half of such amount in the
21 case of a taxpayer whose tax is determined
22 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 |

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

1 "(1) ADVANCE PAYMENT PROGRAM.—
2 "(A) IN GENERAL.—The Secretary of the
3 Treasury, in consultation with the Secretary of
4 Health and Human Services, shall establish a
5 program—
6 "(i) to make advance determinations
7 with respect to the eligibility of individuals
8 for the credit allowed under this section,
9 and
10 "(ii) to make advance payments of the
11 credit allowed under this section, at the
12 election of any such individual so eligible,
13 directly to the health savings account of
14 any such individual, or, as a subsidy to the
15 cost of health insurance coverage provided
16 to any such individual, to the health insur-
17 ance issuer providing such coverage or the
18 person that administers the plan benefits
19 with respect to such coverage.
20 "(B) PROGRAM REQUIREMENTS.—Such
21 program shall be established under rules similar
22 to the rules of section 1412 of the Patient Pro-
23 tection and Affordable Care Act, as in effect on
24 the day before the date of the enactment of this
25 section, except that advance determinations and

1 advance payments shall be made on request of
2 the individual with respect to whom the deter-
3 mination is to be made.
4 "(2) INFORMATION REQUIREMENTS.—
5 "(A) IN GENERAL.—Each person providing
6 health insurance coverage which constitutes
7 medical care, and each trustee of a health sav-
8 ings account, shall provide the following infor-
9 mation to the Secretary and to the taxpayer
10 with respect to such coverage or such account:
11 "(i) The total premium for the cov-
12 erage without regard to the credit under
13 this section.
14 "(ii) The aggregate amount of any ad-
15 vance payment of such credit made with
16 respect to such coverage or to such ac-
17 count.
18 "(iii) The name, address, age, and
19 TIN of the primary insured or account
20 holder (as the case may be) and the name,
21 age, and TIN of each other individual ob-
22 taining coverage under such policy of in-
23 surance.

1 “(iv) Any information provided to
2 such person necessary to determine eligi-
3 bility for, and the amount of, such credit.
4 “(v) Information necessary to deter-
5 mine whether a taxpayer has received ex-
6 cess advance payments.
7 “(B) EXCEPTION.—Subparagraph (A)
8 shall not apply to any coverage with respect to
9 which reporting under section 6051 is required.
10 “(3) INDEXING.—[new/review:]
11 “(A) IN GENERAL.—In the case of any cal-
12 endar year beginning after 2016, each of the
13 dollar amounts in subsection (b)(2) and in the
14 table contained under subsection (d)(2)(B) shall
15 be equal to such dollar amount multiplied by
16 the ratio of—
17 “(i) the current dollar gross domestic
18 product (as determined based on the third
19 estimate of the Bureau of Economic Anal-
20 ysis of the Department of Commerce for
21 the second quarter of the previous year), to
22 “(ii) the current dollar gross domestic
23 product (as so determined) for the second
24 quarter of 2015.

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

5 "(f) CREDITABLE COVERAGE DEFINED.—For pur-
6 poses of this section, the term 'creditable coverage' has
7 the meaning given such term for purposes of title XXVII
8 of the Public Health Service Act.".

9 (b) ELECTION BY EMPLOYER TO MAKE EXCISE TAX
10 APPLICABLE AND TO BE GOVERNED SOLELY BY EXCLU-
11 SION REGIME.—

12 (1) IN GENERAL.—If an eligible employer
13 makes the election under this subsection (at such
14 time and in such form and manner as the Secretary
15 shall prescribe) the tax imposed by section 4980I of
16 the Internal Revenue Code of 1986 shall apply to
17 any excess benefit with respect to employer-spon-
18 sored health coverage provided by such employer and
19 the credit and recapture under section 36C of such
20 Code shall not apply with respect to individuals cov-
21 ered by such coverage. Such election, once made,
22 may be revoked only with the consent of the Sec-
23 retary.

24 (2) ELIGIBLE EMPLOYER.—For purposes of
25 this subsection, the term "eligible employer" means

1 an employer in existence before the date of the en-
2 actment of this Act.

3 (3) CONTROLLED GROUPS.—For purposes of
4 this subsection, all persons treated as a single em-
5 ployer under subsection (a) or (b) of section 52 of
6 the Internal Revenue Code of 1986 or subsection
7 (m) or (o) of section 414 of such Code shall be
8 treated as a single covered entity.

9 (4) REGULATIONS.—The Secretary of the
10 Treasury shall prescribe such regulations as may be
11 necessary to prevent the avoidance of the purposes
12 of this subsection.

13 (c) EXCISE TAX ON HIGH COST EMPLOYER-SPON-
14 SORED HEALTH INSURANCE ONLY TO APPLY TO EM-
15 PLOYERS MAKING ELECTION.—Section 4980I(d)(1)(B) of
16 such Code (relating to exceptions) is amended by striking
17 ''or'' at the end of clause (ii), by striking the period at
18 the end of clause (iii) and inserting '', or'', and by adding
19 at the end the following new clause:

20 ''(iv) any group health plan made
21 available by an employer which does not
22 have in effect an election under section
23 131(b) of the Healthcare Accessibility,
24 Empowerment, and Liberty Act of 2016.''.

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

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

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

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

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

24 (f) CLERICAL AMENDMENT.—The table of sections
25 for subpart C of part IV of subchapter A of chapter 1

1 of the Internal Revenue Code of 1986 is amended by in-
2 serting after the item relating to section 36B the following
3 new item:

"Sec. 36C. Universal health insurance tax credit.".

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

7 **SEC. 132. APPLICATION OF PORTION OF UNUSED TAX**
8 **CREDITS BY STATES FOR INDIGENT HEALTH**
9 **CARE.**

10 (a) COMPUTATION OF UNUSED CREDITS.—The Sec-
11 retary, in consultation with the Secretary of the Treasury,
12 shall calculate for each State for each year, beginning with
13 2017, using the most recent data available —

14 (1) the maximum aggregate amount of credits
15 under section 36C of the Internal Revenue Code of
16 1986 that would have been allowed for the year for
17 residents of the State for taxable years ending in the
18 year if all eligible residents had qualified for such
19 credits;

20 (2) the aggregate amount of credits under such
21 section that were allowed for taxable years ending in
22 that the year by residents of such State; and

23 (3) 25 percent of the amount by which—

1 (A) the amount determined under para-
2 graph (1) with respect to residents of the State
3 for such year; exceeds
4 (B) the amount determined under para-
5 graph (2) for such State for that year.
6 (b) APPROPRIATION.—For the purpose of making
7 grants to States under this section, there is hereby appro-
8 priated to the Secretary, out of any funds in the Treasury
9 not otherwise appropriated, for each year (beginning with
10 2017) an amount equivalent to the amount determined
11 under subsection (a)(3) for all States under subsection (a)
12 for the year in which such fiscal year ends, subject to ad-
13 justment under subsection (d)(2).
14 (c) GRANTS TO STATES FOR INDIGENT ASSIST-
15 ANCE.—
16 (1) APPLICATION.—A State may file with the
17 Secretary (in a form and manner specified by the
18 Secretary) an application to provide assistance in
19 furnishing health services to indigent individuals
20 who are residing in the State. Such application shall
21 demonstrate the manner in which such assistance is
22 furnished in an equitable manner to individuals re-
23 siding in all parts of the State.
24 (2) AMOUNT OF FUNDS.—From the funds ap-
25 propriated under subsection (b) for a year, the

1 amount of funds paid to any State in any year
2 under this section with an application filed in ac-
3 cordance with paragraph (1) is equal to an amount
4 specified in the application, but not to exceed the
5 amount computed under subsection (a)(3) for the
6 State and the year.

7 (3) USE OF FUNDS.—Funds paid to a State
8 under this subsection may be used only to assist in
9 the furnishing of health services to uninsured indi-
10 viduals who are residing in the State or for purposes
11 of increasing the payment adjustments made under
12 sections 1886(d)(5)(F) and 1923 of the Social Secu-
13 rity Act (42 U.S.C. 1395ww(d)(5)(F), 1396r–4) to
14 hospitals that serve a disproportionate share of such
15 individuals in the State.

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

18 (1) USE OF ESTIMATES.—The calculations
19 under subsection (a) for a year shall initially be esti-
20 mated before the beginning of the year. Payments
21 under this section to a State for a year shall be
22 made, subject to reconciliation under paragraph (2),
23 based on the amount so estimated.

24 (2) RECONCILIATION BASED ON FINAL CAL-
25 CULATION.—The calculations under subsection (a)

1 for a year shall also be made after the end of the
2 year. Insofar as the amount calculated under this
3 paragraph for subsection (a)(3) for a State for a
4 year exceeds (or is less than) by a material amount
5 from the amount for subsection (a)(3) estimated and
6 applied for the State and year under paragraph (1),
7 the amount calculated under subsection (a)(3) for
8 the State for the 2nd year beginning after such year,
9 shall be reduced or increased, respectively by the
10 amount of such excess or deficit.

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

13 (a) IN GENERAL.—Notwithstanding any other provi-
14 sion of law, a State plan under title XIX of the Social
15 Security Act (42 U.S.C. 1396 et seq.) may make available
16 to an individual, who is entitled to medical assistance for
17 a full range of acute care items and services under such
18 title and at the individual's option, instead of the medical
19 assistance otherwise provided, medical assistance con-
20 sisting of coverage under a health plan that qualifies for
21 a tax credit under section 36C of the Internal Revenue
22 Code of 1986, but only if the State provides for the indi-
23 vidual medical assistance, in the form of a deposit into
24 a health savings account for the individual, an amount
25 equivalent to the amount by which the amount of tax cred-

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

# 15 TITLE II—IMPROVING HEALTH 16 SAVINGS ACCOUNTS TO PRO- 17 MOTE ACCOUNTABILITY

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

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

22 **"PART IX—HEALTH SAVINGS ACCOUNTS**

"Sec. 530A. Roth HSAs.

1 **"SEC. 530A. ROTH HSAS.**

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

9 "(b) DOLLAR LIMITATION.—

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

16 "(2) MONTHLY LIMITATION.—The monthly lim-
17 itation for any month is 1⁄12 of—

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

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

1 ing the eligible individual) covered under such
2 family creditable coverage as of such day.
3 ''(3) ADDITIONAL CONTRIBUTIONS FOR INDI-
4 VIDUALS 55 OR OLDER.—In the case of an individual
5 who has attained age 55 before the close of the tax-
6 able year, the applicable limitation under subpara-
7 graphs (A) and (B) of paragraph (2) shall be in-
8 creased by $1,000.
9 ''(4) COORDINATION WITH OTHER CONTRIBU-
10 TIONS.—The limitation which would (but for this
11 paragraph) apply under this subsection to an indi-
12 vidual for any taxable year shall be reduced (but not
13 below zero) by the sum of—
14 ''(A) the aggregate amount paid for such
15 taxable year to Archer MSAs of such individual,
16 ''(B) the aggregate amount contributed to
17 Roth HSAs of such individual which is exclud-
18 able from the taxpayer's gross income for such
19 taxable year under section 106(d) (and such
20 amount shall not be allowed as a deduction
21 under subsection (a)), and
22 ''(C) the aggregate amount contributed to
23 Roth HSAs of such individual for such taxable
24 year under section 408(d)(9) (and such amount

1 shall not be allowed as a deduction under sub-
2 section (a)).
3 Subparagraph (A) shall not apply with respect to
4 any individual to whom paragraph (5) applies.
5 "(5) SPECIAL RULE FOR MARRIED INDIVID-
6 UALS.—In the case of individuals who are married
7 to each other, if either spouse has family coverage—
8 "(A) both spouses shall be treated as hav-
9 ing only such family coverage (and if such
10 spouses each have family coverage under dif-
11 ferent plans, as having the family coverage with
12 the lowest annual deductible), and
13 "(B) the limitation under paragraph (1)
14 (after the application of subparagraph (A) and
15 without regard to any additional contribution
16 amount under paragraph (3))—
17 "(i) shall be reduced by the aggregate
18 amount paid to Archer MSAs of such
19 spouses for the taxable year, and
20 "(ii) after such reduction, shall be di-
21 vided equally between them unless they
22 agree on a different division.
23 "(6) DENIAL OF DEDUCTION TO DEPEND-
24 ENTS.—No contribution may be made to a Roth
25 HSA under this section by any individual with re-

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

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

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

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

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

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

1 ductible health plan in which the individual
2 was enrolled for the last month of such
3 taxable year.
4 "(B) FAILURE TO MAINTAIN CREDITABLE
5 COVERAGE.—
6 "(i) IN GENERAL.—If, at any time
7 during the testing period, the individual is
8 not an eligible individual, then—
9 "(I) gross income of the indi-
10 vidual for the taxable year in which
11 occurs the first month in the testing
12 period for which such individual is not
13 an eligible individual is increased by
14 the aggregate amount of all contribu-
15 tions to the Roth HSA of the indi-
16 vidual which could not have been
17 made but for subparagraph (A), and
18 "(II) the tax imposed by this
19 chapter for any taxable year on the
20 individual shall be increased by 10
21 percent of the amount of such in-
22 crease.
23 "(ii) EXCEPTION FOR DISABILITY OR
24 DEATH.—Subclauses (I) and (II) of clause
25 (i) shall not apply if the individual ceased

1 to be an eligible individual by reason of the
2 death of the individual or the individual
3 becoming disabled (within the meaning of
4 section 72(m)(7)).
5 ''(iii) TESTING PERIOD.—The term
6 'testing period' means the period beginning
7 with the last month of the taxable year re-
8 ferred to in subparagraph (A) and ending
9 on the last day of the 12th month fol-
10 lowing such month.
11 ''(c) ROTH HSA.—For purposes of this section—
12 ''(1) IN GENERAL.—The term 'Roth HSA'
13 means a trust created or organized in the United
14 States as a Roth HSA exclusively for the purpose of
15 paying the qualified medical expenses of the account
16 beneficiary, but only if the written governing instru-
17 ment creating the trust meets the following require-
18 ments:
19 ''(A) Except in the case of a rollover con-
20 tribution described in subsection (f)(5) or sec-
21 tion 220(f)(5), no contribution will be accept-
22 ed—
23 ''(i) unless it is in cash, or
24 ''(ii) to the extent such contribution,
25 when added to previous contributions to

1 the trust for the calendar year, exceeds the
2 sum of—
3 "(I) the dollar amount in effect
4 under subsection (b)(2)(B), and
5 "(II) the dollar amount in effect
6 under subsection (b)(3).
7 "(B) The trustee is a bank (as defined in
8 section 408(n)), an insurance company (as de-
9 fined in section 816), or another person who
10 demonstrates to the satisfaction of the Sec-
11 retary that the manner in which such person
12 will administer the trust will be consistent with
13 the requirements of this section.
14 "(C) No part of the trust assets will be in-
15 vested in life insurance contracts.
16 "(D) The assets of the trust will not be
17 commingled with other property except in a
18 common trust fund or common investment
19 fund.
20 "(E) The interest of an individual in the
21 balance in his account is nonforfeitable.
22 "(2) QUALIFIED MEDICAL EXPENSES.—For
23 purposes of this section—
24 "(A) IN GENERAL.—The term 'qualified
25 medical expenses' means, with respect to an ac-

1 count beneficiary, amounts paid by such bene-
2 ficiary for medical care (as defined in section
3 213(d) as in effect on the day before the date
4 of the enactment of the Healthcare Accessi-
5 bility, Empowerment, and Liberty Act of 2016)
6 for such individual, the spouse of such indi-
7 vidual, and any dependent (as defined in section
8 152, determined without regard to subsections
9 (b)(1), (b)(2), and (d)(1)(B) thereof) of such
10 individual, but only to the extent such amounts
11 are not compensated for by insurance or other-
12 wise.

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

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

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

1 "(ii) a qualified long-term care insur-
2 ance contract (as defined in section
3 7702B(b)),
4 "(iii) a health plan during a period in
5 which the individual is receiving unemploy-
6 ment compensation under any Federal or
7 State law, or
8 "(iv) in the case of an account bene-
9 ficiary who has attained the age specified
10 in section 1811 of the Social Security Act,
11 any health insurance other than a medi-
12 care supplemental policy (as defined in sec-
13 tion 1882 of the Social Security Act).
14 "(3) ACCOUNT BENEFICIARY.—The term 'ac-
15 count beneficiary' means the individual on whose be-
16 half the Roth HSA was established.
17 "(4) CERTAIN RULES TO APPLY.—Rules similar
18 to the following rules shall apply for purposes of this
19 section:
20 "(A) Section 219(f)(3) (relating to time
21 when contributions deemed made).
22 "(B) Except as provided in section 106(d),
23 section 219(f)(5) (relating to employer pay-
24 ments).

1 "(C) Section 408(g) (relating to commu-
2 nity property laws).
3 "(D) Section 408(h) (relating to custodial
4 accounts).
5 "(d) ELIGIBLE INDIVIDUAL; CREDITABLE COV-
6 ERAGE.—For purposes of this section—
7 "(1) ELIGIBLE INDIVIDUAL.—The term 'eligible
8 individual' means, with respect to any month, any
9 individual if such individual is covered under cred-
10 itable coverage as of the 1st day of such month.
11 "(2) CREDITABLE COVERAGE.—The term 'cred-
12 itable coverage' shall have the meaning given such
13 term in section 36C(f).
14 "(e) TAX TREATMENT OF DISTRIBUTIONS.—
15 "(1) AMOUNTS USED FOR QUALIFIED MEDICAL
16 EXPENSES.—Any amount paid or distributed out of
17 a Roth HSA which is used exclusively to pay quali-
18 fied medical expenses of any account beneficiary
19 shall not be includible in gross income.
20 "(2) INCLUSION OF AMOUNTS NOT USED FOR
21 QUALIFIED MEDICAL EXPENSES.—Any amount paid
22 or distributed out of a Roth HSA which is not used
23 exclusively to pay the qualified medical expenses of
24 the account beneficiary shall be included in the gross
25 income of such beneficiary.

1 "(3) EXCESS CONTRIBUTIONS RETURNED BE-
2 FORE DUE DATE OF RETURN.—
3 "(A) IN GENERAL.—If any excess con-
4 tribution is contributed for a taxable year to
5 any Roth HSA of an individual, paragraph (2)
6 shall not apply to distributions from the Roth
7 HSAs of such individual (to the extent such dis-
8 tributions do not exceed the aggregate excess
9 contributions to all such accounts of such indi-
10 vidual for such year) if—
11 "(i) such distribution is received by
12 the individual on or before the last day
13 prescribed by law (including extensions of
14 time) for filing such individual's return for
15 such taxable year, and
16 "(ii) such distribution is accompanied
17 by the amount of net income attributable
18 to such excess contribution.
19 Any net income described in clause (ii) shall be
20 included in the gross income of the individual
21 for the taxable year in which it is received.
22 "(B) EXCESS CONTRIBUTION.—For pur-
23 poses of subparagraph (A), the term 'excess
24 contribution' means any contribution (other
25 than a rollover contribution described in para-

1 graph (5) or section 220(f)(5)) which exceeds
2 the contribution limitation with respect to the
3 individual for the taxable year.
4 "(4) ADDITIONAL TAX ON DISTRIBUTIONS NOT
5 USED FOR QUALIFIED MEDICAL EXPENSES.—
6 "(A) IN GENERAL.—The tax imposed by
7 this chapter on the account beneficiary for any
8 taxable year in which there is a payment or dis-
9 tribution from a Roth HSA of such beneficiary
10 which is includible in gross income under para-
11 graph (2) shall be increased by 10 percent of
12 the amount which is so includible.
13 "(B) EXCEPTION FOR DISABILITY OR
14 DEATH.—Subparagraph (A) shall not apply if
15 the payment or distribution is made after the
16 account beneficiary becomes disabled within the
17 meaning of section 72(m)(7) or dies.
18 "(C) EXCEPTION FOR DISTRIBUTIONS
19 AFTER MEDICARE ELIGIBILITY.—Subparagraph
20 (A) shall not apply to any payment or distribu-
21 tion after the date on which the account bene-
22 ficiary attains the age specified in section 1811
23 of the Social Security Act.
24 "(5) ROLLOVER CONTRIBUTION.—An amount is
25 described in this paragraph as a rollover contribu-

1 tion if it meets the requirements of subparagraphs
2 (A) and (B).
3 "(A) IN GENERAL.—Paragraph (2) shall
4 not apply to any amount paid or distributed
5 from a health savings account (as defined in
6 section 223) or a Roth HSA to the account
7 beneficiary to the extent the amount received is
8 paid into a Roth HSA for the benefit of such
9 beneficiary not later than the 60th day after
10 the day on which the beneficiary receives the
11 payment or distribution.
12 "(B) LIMITATION.—This paragraph shall
13 not apply to any amount described in subpara-
14 graph (A) received by an individual from a
15 health savings account or a Roth HSA if, at
16 any time during the 1-year period ending on the
17 day of such receipt, such individual received any
18 other amount described in subparagraph (A)
19 from a health savings account or Roth HSA
20 which was not includible in the individual's
21 gross income because of the application of this
22 paragraph.
23 "(6) TRANSFER OF ACCOUNT INCIDENT TO DI-
24 VORCE.—The transfer of an individual's interest in
25 a Roth HSA to an individual's spouse or former

1 spouse under a divorce or separation instrument de-
2 scribed in subparagraph (A) of section 71(b)(2) shall
3 not be considered a taxable transfer made by such
4 individual notwithstanding any other provision of
5 this subtitle, and such interest shall, after such
6 transfer, be treated as a Roth HSA with respect to
7 which such spouse is the account beneficiary.

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

14 "(f) COST-OF-LIVING ADJUSTMENT.—

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

19 "(A) such dollar amount, multiplied by

20 "(B) the cost-of-living adjustment deter-
21 mined under section 1(f)(3) for the calendar
22 year, determined—

23 "(i) by substituting 'calendar year
24 2015' for 'calendar year 1992' in subpara-
25 graph (B) thereof, and

1 ‘‘(ii) by substituting ‘CPI medical care
2 component’ for ‘CPI’.
3 ‘‘(2) CPI MEDICAL CARE COMPONENT.—For
4 purposes of this paragraph, the term ‘CPI medical
5 care component’ means the medical care component
6 for the Consumer Price Index for All Urban Con-
7 sumers published by the Department of Labor.
8 ‘‘(3) ROUNDING.—If the amount of any in-
9 crease under the preceding sentence is not a mul-
10 tiple of $50, such increase shall be rounded to the
11 next lowest multiple of $50.
12 ‘‘(g) REPORTS.—The Secretary may require—
13 ‘‘(1) the trustee of a Roth HSA to make such
14 reports regarding such account to the Secretary and
15 to the account beneficiary with respect to contribu-
16 tions, distributions, the return of excess contribu-
17 tions, and such other matters as the Secretary deter-
18 mines appropriate, and
19 ‘‘(2) any person who provides an individual with
20 creditable coverage to make such reports to the Sec-
21 retary and to the account beneficiary with respect to
22 such plan as the Secretary determines appropriate.
23 The reports required by this subsection shall be filed at
24 such time and in such manner and furnished to such indi-

1 viduals at such time and in such manner as may be re-
2 quired by the Secretary.''.
3 (b) LIMIT ON CONTRIBUTIONS TO DEDUCTIBLE
4 HEALTH SAVINGS ACCOUNTS.—Section 223 of such Code
5 is amended by adding at the end the following new sub-
6 section:
7 ''(i) LIMITED CONTRIBUTIONS AFTER 2016.—
8 ''(1) IN GENERAL.—No contribution may be ac-
9 cepted by a health savings account after December
10 31, 2016.
11 ''(2) EXCEPTIONS.—Paragraph (1) shall not
12 apply—
13 ''(A) in the case of a rollover contribution
14 described in subsection (f)(5) or section
15 220(f)(5), or
16 ''(B) in the case of a month for which an
17 individual is covered by insurance that con-
18 stitutes medical care and that is provided by an
19 employer with respect to which an election is in
20 effect for such month under section 131(b) of
21 the Healthcare Accessibility, Empowerment,
22 and Liberty Act of 2016.''.
23 (c) CLERICAL AMENDMENT.—The table of parts for
24 subchapter F of such Code is amended by adding a the
25 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.

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

2 (a) HSAS.—

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

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

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

20 (1) IN GENERAL.—For purposes of title XXVII
21 of the Public Health Service Act, subtitle B of title
22 I of the Employee Retirement and Income Security
23 Act of 1974, PPACA, and this Act, the offering of
24 concierge medicine [by itself] shall not be treated as
25 the offering of health insurance coverage and shall

1 not be subject to regulations as such coverage under
2 such Acts.
3 (2) CONCIERGE MEDICINE DEFINED.—In this
4 subsection, the term ''concierge medicine'' means the
5 furnishing (or access to the furnishing) by a physi-
6 cian or group of physicians of physician professional
7 services (and ancillary services) in return for pay-
8 ment of a monthly or other prepaid amount.

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

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

14 (a) IN GENERAL.—States are given the flexibility
15 under section 122(b) to revise their regulations of the
16 health insurance marketplace, without regard to many of
17 the requirements imposed under PPACA, in order to pro-
18 mote freedom of choice of affordable health insurance cov-
19 erage options offered outside of an Exchange.
20 (b) CONSTRUCTION.—Nothing in the Employee Re-
21 tirement and Income Security Act of 1974 or of any
22 amendments made by the Health Insurance Portability
23 and Accountability Act of 1996 shall be interpreted as pre-
24 venting an employer from offering, or making an employer

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

# 3 TITLE IV—MEDICAID PAYMENT 4 REFORM

5 **SEC. 401. MEDICAID PAYMENT REFORM.**

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

9 **"SEC. 1903A. REFORMED PAYMENT TO STATES.**

10 "(a) REFORMED PAYMENT SYSTEM.—
11 "(1) IN GENERAL.—For quarters beginning on
12 or after the implementation date (as defined in sub-
13 section (k)(1)), in lieu of amounts otherwise payable
14 to a State under this title (including any payments
15 attributable to section 1923), except as otherwise
16 provided in this section, the amount payable to such
17 State shall be equal to the sum of the following:
18 "(A) ADJUSTED AGGREGATE BENE-
19 FICIARY-BASED AMOUNT.—The aggregate bene-
20 ficiary-based amount specified in subsection (b)
21 for the quarter and the State, adjusted under
22 subsection (e).
23 "(B) CHRONIC CARE QUALITY BONUS.—
24 The amount (if any) of the chronic care quality

1 bonus payment specified in subsection (f) for
2 the quarter for the State.
3 "(2) REQUIREMENT OF STATE SHARE.—
4 "(A) IN GENERAL.—A State shall make,
5 from non-Federal funds, expenditures in an
6 amount equal to its State share (as determined
7 under subparagraph (B)) for a quarter for
8 items, services, and other costs for which, but
9 for paragraph (1), Federal funds would have
10 been payable under this title.
11 "(B) STATE SHARE.—The State share for
12 a State for a quarter in a fiscal year is equal
13 to the product of—
14 "(i) the aggregate beneficiary-based
15 amount specified in subsection (b) for the
16 quarter and the State; and
17 "(ii) the ratio of—
18 "(I) the State percentage de-
19 scribed in subparagraph (D)(ii) for
20 such State and fiscal year; to
21 "(II) the Federal percentage de-
22 scribed in subparagraph (D)(i) for
23 such State and fiscal year.
24 "(C) NONPAYMENT FOR FAILURE TO PAY
25 STATE SHARE.—

1 "(i) IN GENERAL.—If a State fails to
2 expend the amount required under sub-
3 paragraph (A) for a quarter in a fiscal
4 year, the amount payable to the State
5 under paragraph (1) shall be reduced by
6 the product of the amount by which the
7 State payment is less than the State share
8 and the ratio of—
9 "(I) the Federal percentage de-
10 scribed in subparagraph (D)(i) for
11 such State and fiscal year; to
12 "(II) the State percentage de-
13 scribed in subparagraph (D)(ii) for
14 such State and fiscal year.
15 "(ii) GRACE PERIOD.—A State shall
16 not be considered to have failed to provide
17 payment of its required State share for a
18 quarter under subparagraph (A) if the ag-
19 gregate State payment towards the State's
20 required State share for the 4-quarter pe-
21 riod beginning with such quarter exceeds
22 the required State share amount for such
23 4-quarter period.

1 "(D) FEDERAL AND STATE PERCENT-
2 AGES.—In this paragraph, with respect to a
3 State and a fiscal year:
4 "(i) FEDERAL PERCENTAGE.—The
5 Federal percentage described in this clause
6 is 75 percent or, if higher, the Federal
7 medical assistance percentage for such
8 State for such fiscal year.
9 "(ii) STATE PERCENTAGE.—The State
10 percentage described in this clause is 100
11 percent minus the Federal percentage de-
12 scribed in clause (i).
13 "(E) RULES FOR CREDITING TOWARD
14 STATE SHARE.—
15 "(i) GENERAL LIMITATION TO MATCH-
16 ABLE EXPENDITURES.—A payment for ex-
17 penditures shall not be counted toward the
18 State share under subparagraph (A) unless
19 Federal payments may be used for such
20 expenditures consistent with paragraph
21 (3)(B).
22 "(ii) FURTHER LIMITATIONS ON AL-
23 LOWABLE EXPENDITURES.—A payment for
24 expenditures shall not be counted towards

1 the State share under subparagraph (A) if
2 the expenditure is for any of the following:
3 "(I) ABORTION.—Expenditures
4 for an abortion.
5 "(II) INTERGOVERNMENTAL
6 TRANSFERS.—An expenditure that is
7 attributable to an intergovernmental
8 transfer.
9 "(III) CERTIFIED PUBLIC EX-
10 PENDITURES.—An expenditure that is
11 attributable to certified public expend-
12 itures.
13 "(iii) CREDITING FRAUD AND ABUSE
14 RECOVERIES.—Amounts recovered by a
15 State through the operation of its Medicaid
16 fraud and abuse control unit described in
17 section 1903(q) shall be fully counted to-
18 ward the State share under subparagraph
19 (A).
20 "(F) CONSTRUCTION.—Nothing in the
21 paragraph shall be construed as preventing a
22 State from expending, from non-Federal funds,
23 an amount under this title in excess of the
24 amount of the State share.

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

11 "(3) USE OF FEDERAL PAYMENTS.—

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

17 "(B) LIMITATION FOR CERTAIN ELIGI-
18 BLES.—

19 "(i) APPLICATION OF 100 PERCENT
20 FEDERAL POVERTY LINE LIMIT ON ELIGI-
21 BILITY.—Subject to clause (iii), a State
22 may not use such Federal payments to
23 provide medical assistance for an indi-
24 vidual who has an income (as determined
25 under clause (ii)) that exceeds 100 percent

1 of the poverty line (as defined in section
2 2110(c)(5)) applicable to a family of the
3 size involved.

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

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

21 "(II) DISREGARD OF 5 PERCENT
22 INCREASE.—Subparagraph (I) of sec-
23 tion 1902(e)(14) (relating to a 5 per-
24 cent reduction) shall not apply.

1 "(iii) EXCEPTION.—Clause (i) shall
2 not apply to an individual who is—
3 "(I) a woman described in clause
4 (i) of section 1903(v)(4)(A);
5 "(II) a child who is an individual
6 described in clause (i) of section
7 1905(a);
8 "(III) enrolled in a State plan
9 under this title as of the date of the
10 enactment of this section for the pe-
11 riod of continuous enrollment; or
12 "(IV) described in section
13 1902(e)(14)(D) (relating to modified
14 adjusted gross income).
15 "(iv) CLARIFICATION RELATED TO
16 COMMUNITY SPOUSE.—Nothing in this
17 subparagraph shall supersede the applica-
18 tion of section 1924 (related to community
19 spouse income and assets).
20 "(4) EXCEPTIONS FOR PASS-THROUGH PAY-
21 MENTS.—
22 "(A) IN GENERAL.—Paragraph (1) shall
23 not apply, and amounts shall continue to be
24 payable under this title (and not under sub-
25 section (a)), in the case of the following pay-

1 ments (and related administrative costs and ex-
2 penditures):
3 "(i) PAYMENTS TO TERRITORIES.—
4 Payments to a State other than the 50
5 States and the District of Columbia.
6 "(ii) MEDICARE COST SHARING.—
7 Payments attributable to Medicare cost
8 sharing under section 1905(p).
9 "(iii) PEDIATRIC VACCINES.—Pay-
10 ments attributable to section 1928.
11 "(iv) EMERGENCY SERVICES FOR CER-
12 TAIN INDIVIDUALS.—Payments for treat-
13 ment of emergency medical conditions at-
14 tributable to the application of section
15 1903(v)(2).
16 "(v) INDIAN HEALTH CARE FACILI-
17 TIES.—Payments for medical assistance
18 described in the third sentence of section
19 1905(b).
20 "(vi) EMPLOYER-SPONSORED INSUR-
21 ANCE (ESI).—Payments for medical assist-
22 ance attributable to payments to employers
23 for employer-sponsored health benefits cov-
24 erage.

1 "(vii) OTHER POPULATIONS WITH
2 LIMITED BENEFIT COVERAGE.—Other pay-
3 ments that are determined by the Sec-
4 retary to be related to a specified popu-
5 lation for which the medical assistance
6 under this title is limited and does not in-
7 clude any inpatient, nursing facility, or
8 long-term care services.
9 "(B) CERTAIN EXPENSES.—Paragraph (1)
10 shall not apply, and amounts shall continue to
11 be payable under this title (and not under sub-
12 section (a)), in the case of the following:
13 "(i) ADMINISTRATION OF MEDICARE
14 PRESCRIPTION DRUG BENEFIT.—Expendi-
15 tures described in section 1935(b) (relating
16 to administration of the Medicare prescrip-
17 tion drug benefit).
18 "(ii) PAYMENTS FOR HIT BONUSES.—
19 Payments under section 1903(a)(3)(F) (re-
20 lating to payments to encourage the adop-
21 tion and use of certified EHR technology).
22 "(iii) PAYMENTS FOR DESIGN, DEVEL-
23 OPMENT, AND INSTALLATION OF MMIS AND
24 ELIGIBILITY SYSTEMS.—Payments under
25 subparagraphs (A)(i) and (H)(i) of section

1 1903(a)(3) for expenditures for design, de-
2 velopment, and installation of the Medicaid
3 management information systems and
4 mechanized verification and information
5 retrieval systems (related to eligibility).
6 ''(5) PAYMENT OF AMOUNTS.—
7 ''(A) IN GENERAL.—Except as the Sec-
8 retary may otherwise provide, amounts shall be
9 payable to a State under subsection (a) in the
10 same manner as amounts are payable under
11 subsection (d) of section 1903 to a State under
12 subsection (a) of such section.
13 ''(B) INFORMATION AND FORMS.—
14 ''(i) SUBMISSION.—As a condition of
15 receiving payment under subsection (a), a
16 State shall submit such information, in
17 such form, and manner, as the Secretary
18 shall specify, including information nec-
19 essary to make the computations under
20 subsections (c)(2)(C) and (e).
21 ''(ii) UNIFORM REPORTING.—The
22 Secretary shall develop such forms as may
23 be needed to assure a system of uniform
24 reporting of such information across
25 States.

1 "(C) REQUIRED REPORTING OF INFORMA-
2 TION ON MEDICAL LOSS RATIOS FOR MANAGED
3 CARE.—The information required to be reported
4 under subparagraph (B)(i) shall include infor-
5 mation on the medical loss ratio with respect to
6 coverage provided under each Medicaid man-
7 aged care plan with a contract with the State
8 under section 1903(m) or 1932.
9 "(b) AGGREGATE BENEFICIARY-BASED AMOUNT.—
10 "(1) IN GENERAL.—The aggregate beneficiary-
11 based amount specified in this subsection for a State
12 for a quarter is equal to the sum of the products,
13 for each of the categories of Medicaid beneficiaries
14 specified in paragraph (2), of the following:
15 "(A) BENEFICIARY-BASED QUARTERLY
16 AMOUNT.—The beneficiary-based quarterly
17 amount for such category computed under sub-
18 section (c) for such State for such quarter.
19 "(B) NUMBER OF INDIVIDUALS IN CAT-
20 EGORY.—Subject to subsection (d), the average
21 number of Medicaid beneficiaries enrolled in
22 such category in the State in such quarter.
23 "(2) CATEGORIES.—The categories specified in
24 this paragraph are the following:

1 "(A) ELDERLY.—A category of Medicaid
2 beneficiaries who are 65 years of age or older.
3 "(B) BLIND OR DISABLED.—A category of
4 Medicaid beneficiaries not described in subpara-
5 graph (A) who are described in section
6 1937(a)(2)(B)(ii).
7 "(C) CHILDREN.—A category of Medicaid
8 beneficiaries not described in subparagraph (B)
9 who are under 21 years of age.
10 "(D) OTHER ADULTS.—A category of any
11 Medicaid beneficiaries who are not described in
12 a previous subparagraph of this paragraph.
13 "(c) COMPUTATION OF PER BENEFICIARY, PER CAT-
14 EGORY QUARTERLY AMOUNT.—
15 "(1) IN GENERAL.—For a State, for each cat-
16 egory of beneficiary for a quarter—
17 "(A) FIRST REFORM YEAR.—For quarters
18 in the first reform year (as defined in sub-
19 section (k)(2)), the beneficiary-based quarterly
20 amount is equal to ¼ of the base average per
21 beneficiary Federal payments for such State for
22 such category determined under paragraph (2),
23 increased by a factor that reflects the sum of
24 the following:

1 "(i) HISTORICAL MEDICAL CARE COM-
2 PONENT OF CPI THROUGH PREVIOUS RE-
3 FORM YEAR.—The percentage increase in
4 the historical medical care component of
5 the Consumer Price Index for all urban
6 consumers (U.S. city average) from the
7 midpoint of the base fiscal year (as defined
8 in paragraph (6)) to the midpoint of the
9 fiscal year preceding the first reform year.
10 "(ii) PROJECTED MEDICAL CARE COM-
11 PONENT OF CPI FOR THE FIRST REFORM
12 YEAR.—The percentage increase in the
13 projected medical care component of the
14 Consumer Price Index for all urban con-
15 sumers (U.S. city average) from the mid-
16 point of the previous fiscal year referred to
17 in clause (i) to the midpoint of the first re-
18 form year.
19 "(B) SECOND AND THIRD REFORM
20 YEARS.—The beneficiary-based quarterly
21 amount for a State for a category for quarters
22 in the second reform year or the third reform
23 year is equal to the beneficiary-based quarterly
24 amount under this paragraph for such State
25 and category for the previous reform year in-

1 creased by the per beneficiary percentage in-
2 crease (as defined in subparagraph (E)) for
3 such category and reform year.
4 "(C) FOURTH THROUGH TENTH REFORM
5 YEARS.—The beneficiary-based quarterly
6 amount for a State for a category for quarters
7 in a reform year beginning with the fourth re-
8 form year and ending with the tenth reform
9 year is—
10 "(i) in the case of a State that is a
11 high per beneficiary State or a low per
12 beneficiary State (as defined in paragraph
13 (4)(B)(iii)) for the category, the amount
14 determined under clause (i) or (ii) of para-
15 graph (4)(B) for such State, category, and
16 reform year; or
17 "(ii) in the case of any other State,
18 the beneficiary-based quarterly amount
19 under this paragraph for such State and
20 category for the previous reform year in-
21 creased by the per beneficiary percentage
22 increase for such category and reform
23 year.
24 "(D) ELEVENTH REFORM YEAR AND SUB-
25 SEQUENT REFORM YEARS.—The beneficiary-

1 based quarterly amount for a State for a cat-
2 egory for quarters in a reform year beginning
3 with the eleventh reform year is equal to the
4 beneficiary-based quarterly amount under this
5 paragraph for such State and category for the
6 previous reform year increased by the per bene-
7 ficiary percentage increase for such category
8 and reform year.

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

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

20 "(ii) one percentage point.

21 "(2) BASE PER BENEFICIARY, PER CATEGORY
22 AMOUNT FOR EACH STATE.—

23 "(A) AVERAGE PER CATEGORY.—

24 "(i) IN GENERAL.—The Secretary
25 shall determine, consistent with this para-

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

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

18 "(iii) UPDATES.—The determination
19 under clause (i) shall be updated by the
20 Secretary on an annual basis based upon
21 improved data. The Secretary shall adjust
22 the amounts under subsection (a)(1)(A) to
23 reflect changes in the amounts so deter-
24 mined based on such updates.

1 "(B) EXCLUSION OF PASS-THROUGH PAY-
2 MENTS.—In computing base per beneficiary,
3 per category amounts under subparagraph
4 (A)(i) the Secretary shall exclude payments de-
5 scribed in subsection (a)(4).
6 "(C) STANDARDIZATION.—
7 "(i) IN GENERAL.—In computing each
8 such amount, the Secretary shall stand-
9 ardize the amount in order to remove the
10 variation attributable to the following:
11 "(I) RISK FACTORS.—Such risk
12 factors as age, health and disability
13 status (including high cost medical
14 conditions), gender, institutional sta-
15 tus, and such other factors as the
16 Secretary determines to be appro-
17 priate, so as to ensure actuarial
18 equivalence.
19 "(II) GEOGRAPHIC.—Variations
20 in costs on a county-by-county basis.
21 "(ii) METHOD OF STANDARDIZA-
22 TION.—
23 "(I) CONSULTATION IN DEVEL-
24 OPMENT OF RISK STANDARDIZA-
25 TION.—In developing the methodology

1 for risk standardization for purposes
2 of clause (i)(I), the Secretary shall
3 consult with the Medicaid and CHIP
4 Payment and Access Commission, the
5 Medicare Payment Advisory Commis-
6 sion, and the National Association of
7 Medicaid Directors.
8 "(II) METHOD FOR RISK STAND-
9 ARDIZATION.—In carrying out clause
10 (i)(I), the Secretary may apply the
11 hierarchal condition category method-
12 ology under section 1853(a)(1)(C). If
13 the Secretary uses such methodology,
14 the Secretary shall adjust the applica-
15 tion of such methodology to take into
16 account the differences in services
17 provided under this title compared to
18 title XVIII, such as the coverage of
19 long term care, pregnancy, and pedi-
20 atric services.
21 "(III) METHOD FOR GEOGRAPHIC
22 STANDARDIZATION.—The Secretary
23 shall apply the standardization under
24 clause (i)(II) in a manner similar to

1 that applied under section
2 1853(c)(4)(A)(iii).
3 "(iii) APPLICATION ON A NATIONAL,
4 BUDGET NEUTRAL BASIS.—The standard-
5 ization under clause (i) shall be designed
6 and implemented on a uniform national
7 basis and shall be budget neutral so as to
8 not result in any aggregate change in pay-
9 ments under subsection (a).
10 "(iv) RESPONSE TO NEW RISK.—Sub-
11 ject to clause (iii), the Secretary may ad-
12 just the standardization under clause (i) to
13 respond promptly to new instances of com-
14 municable diseases and other public health
15 hazards.
16 "(v) REFERENCE TO APPLICATION OF
17 RISK ADJUSTMENT.—For rules related to
18 the application of risk adjustment to
19 amounts under subsection (a)(1)(A), see
20 subsection (e).
21 "(D) ADJUSTMENT FOR TEMPORARY FMAP
22 INCREASES.—In computing each base per bene-
23 ficiary, per category amounts under subpara-
24 graph (A)(i) the Secretary shall disregard por-
25 tions of payments that are attributable to a

1 temporary increase in the Federal matching
2 rates, including those attributable to the fol-
3 lowing:
4 "(i) PPACA DISASTER FMAP.—Sec-
5 tion 1905(aa).
6 "(ii) ARRA.—Section 5001 of the
7 American Recovery and Reinvestment Act
8 of 2009 (42 U.S.C. 1396d note).
9 "(iii) EXTRAORDINARY EMPLOYER
10 PENSION CONTRIBUTION.—Section 614 of
11 the Children's Health Insurance Program
12 Reauthorization Act of 2009 (42 U.S.C.
13 1396d note).
14 "(3) ALLOCATION OF NONMEDICAL ASSISTANCE
15 PAYMENTS.—The Secretary shall establish rules for
16 the allocation of payments under this title (other
17 than those payments described in paragraph (1) or
18 (5) of section 1903(a) and including such payments
19 attributable to section 1923)—
20 "(A) among different categories of bene-
21 ficiaries; and
22 "(B) between payments included under
23 subsection (a)(1) and payments described in
24 subsection (a)(4).

1 "(4) TRANSITION TO A CORRIDOR AROUND THE
2 NATIONAL AVERAGE.—
3 "(A) DETERMINATION OF NATIONAL AVER-
4 AGE BASE PER BENEFICIARY, PER CATEGORY
5 AMOUNT.—Subject to subparagraph (C), the
6 Secretary shall determine a national average
7 base per beneficiary, per category amount equal
8 to the average of the base per beneficiary, per
9 category amounts for each of the 50 States and
10 the District of Columbia determined under
11 paragraph (2), weighted by the average number
12 of beneficiaries in each such category and State
13 as determined by the Secretary consistent with
14 subsection (d) for the base fiscal year.
15 "(B) TRANSITION ADJUSTMENT.—
16 "(i) HIGH PER BENEFICIARY
17 STATES.—In the case of a high per bene-
18 ficiary State (as defined in clause (iii)(I))
19 for a category, the beneficiary-based quar-
20 terly amount for such State and category
21 for a quarter in a reform year (beginning
22 with the fourth reform year and ending
23 with the tenth reform year) is equal to the
24 sum of—

1 "(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

11 "(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.

24 "(ii) LOW PER BENEFICIARY STATES.—In the case of a low per bene-

1 ficiary State (as defined in clause (iii)(II))
2 for a category, the beneficiary-based quar-
3 terly amount for such State and category
4 for a quarter in a reform year (beginning
5 with the fourth reform year and ending
6 with the tenth reform year) is equal to the
7 sum of—

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

18 ''(II) the product of 1 minus the
19 State-specific factor for such reform
20 year and the beneficiary-based quar-
21 terly amount that would otherwise be
22 determined under paragraph (1) for a
23 State and category if the base per
24 beneficiary, per category amount de-
25 termined under paragraph (2) for the

1 State and category were equal to 90
2 percent of the national average base
3 per beneficiary, per category amount
4 determined under subparagraph (A)
5 for such category.
6 "(iii) HIGH AND LOW PER BENE-
7 FICIARY STATES DEFINED.—In this sub-
8 paragraph:
9 "(I) HIGH PER BENEFICIARY
10 STATE.—The term 'high per bene-
11 ficiary State' means, with respect to a
12 category, a State for which the base
13 per beneficiary, per category amount
14 determined under paragraph (2) for
15 such category is greater than 110 per-
16 cent of the national average base per
17 beneficiary, per category amount de-
18 termined under subparagraph (A) for
19 such category.
20 "(II) LOW PER BENEFICIARY
21 STATE.—The term 'low per bene-
22 ficiary State' means, with respect to a
23 category, a State for which the base
24 per beneficiary, per category amount
25 determined under paragraph (2) for

1 such category is less than 90 percent
2 of the national average base per bene-
3 ficiary, per category amount deter-
4 mined under subparagraph (A) for
5 such category.
6 "(iv) STATE-SPECIFIC FACTOR.—In
7 this subparagraph, the term 'State-specific
8 factor' means—
9 "(I) for the fourth reform year,
10 7/8; and
11 "(II) for a subsequent reform
12 year, the State-specific factor under
13 this clause for the previous reform
14 year minus 1/8.
15 "(C) NO ADDITIONAL EXPENDITURES.—
16 "(i) DETERMINATION OF INCREASE IN
17 FEDERAL EXPENDITURES.—For each cat-
18 egory for each reform year (beginning with
19 the fourth reform year and ending with the
20 tenth reform year), the Secretary shall de-
21 termine whether the application of this
22 paragraph—
23 "(I) to the category for the re-
24 form year will result in an aggregate

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

1 "(A) REPORT TO STATES.—Not later than
2 8 months after the date of the enactment of
3 this section, the Secretary shall submit to each
4 State the Secretary's initial determination of—
5 "(i) the base per beneficiary, per cat-
6 egory amounts under paragraph (2) for
7 such State; and
8 "(ii) the national average base per
9 beneficiary, per category amounts under
10 paragraph (4)(A).
11 "(B) OPPORTUNITY TO APPEAL.—Not
12 later than 3 months after the date a State re-
13 ceives notice of the Secretary's initial deter-
14 mination of such base per beneficiary, per cat-
15 egory amounts for such State under subpara-
16 graph (A)(i), the State may file with the Sec-
17 retary, in a form and manner specified by the
18 Secretary, an appeal of such determination.
19 "(C) DETERMINATION ON APPEAL.—Not
20 later than 3 months after receiving such an ap-
21 peal, the Secretary shall make a final deter-
22 mination on such amounts for such State. If no
23 such appeal is received for a State, the Sec-
24 retary's initial determination under subpara-
25 graph (A)(i) shall become final.

1 "(6) BASE FISCAL YEAR DEFINED.—In this
2 section, the term 'base fiscal year' means the latest
3 fiscal year, ending before the date of the enactment
4 of this section, for which the Secretary determines
5 that adequate data are available to make the com-
6 putations required under this subsection.
7 "(d) NOT COUNTING INDIVIDUALS TO ACCOUNT FOR
8 EXCLUDED PAYMENTS.—Under rules specified by the
9 Secretary, individuals shall not be counted as Medicaid
10 beneficiaries for purposes of subsection (b)(1)(B) and sub-
11 section (c)(2)(A) in proportion to the extent that such in-
12 dividuals are receiving medical assistance for which pay-
13 ments described under subsection (a)(4)(A) are made.
14 "(e) RISK ADJUSTMENT.—
15 "(1) IN GENERAL.—The amount under sub-
16 section (a)(1)(A) shall be adjusted under this sub-
17 section in an appropriate manner, specified by the
18 Secretary and consistent with paragraph (2), to take
19 into account—
20 "(A) the factors described in subsection
21 (c)(2)(C)(i)(I) within a category of bene-
22 ficiaries; and
23 "(B) variations in costs on a county-by-
24 county basis for medical assistance and admin-
25 istrative expenses.

1 "(2) METHOD OF ADJUSTMENT.—
2 "(A) IN GENERAL.—The adjustments
3 under paragraph (1) shall be made in a manner
4 similar to the manner in which similar adjust-
5 ments are made under subsection (c)(2)(C) and
6 consistent with the requirements of clause (iii)
7 of such subsection and subparagraph (B).
8 "(B) BIANNUAL UPDATE OF RISK ADJUST-
9 MENT METHODOLOGY.—In applying clause
10 (i)(I) of subsection (c)(2)(C) for purposes of
11 subparagraph (A), the Secretary shall, in con-
12 sultation with the entities described in clause
13 (ii)(I) of such subsection, update the risk ad-
14 justment methodology applied as appropriate
15 not less often than every 2 years.
16 "(f) CHRONIC CARE QUALITY BONUS PAYMENTS.—
17 "(1) DETERMINATION OF BONUS PAYMENTS.—
18 If the Secretary determines that, based on the re-
19 ports under paragraph (5), with respect to cat-
20 egories of chronic disease for which chronic care per-
21 formance targets had been established under para-
22 graph (3) for each category of Medicaid beneficiaries
23 specified under subsection (b)(2) such targets have
24 been met by a State for a reform year, the Secretary
25 shall make an additional payment to such State in

1 the amount specified in paragraph (6) for each quar-
2 ter in the succeeding reform year. Such payments
3 shall be made in a manner specified by the Secretary
4 and may only be used consistent with subsection
5 (a)(3).

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

11 "(3) ADOPTION OF QUALITY MEASUREMENT
12 SYSTEM AND IDENTIFICATION OF PERFORMANCE
13 TARGETS.—

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

22 "(B) TARGETS.—Using such system and
23 data, the Secretary shall establish for each re-
24 form year the chronic care performance targets
25 for purposes of the payments under paragraph

1 (1). Such performance targets shall be estab-
2 lished in consultation with States, associations
3 representing individuals with chronic illnesses,
4 entities providing treatment to such individuals
5 for such chronic illnesses, and other stake-
6 holders, including the National Association of
7 Medicaid Directors and the National Governors
8 Association.
9 ''(4) DATA TO BE USED.—The data to be used
10 under paragraph (3) shall include—
11 ''(A) data collected through methods such
12 as—
13 ''(i) the 'Healthcare Effectiveness
14 Data and Information Set' (also known as
15 'HEDIS') (or an appropriate successor
16 performance measurement tool);
17 ''(ii) the 'Consumer Assessment of
18 Healthcare Providers and Systems' (also
19 known as 'CAHPS') (or an appropriate
20 successor performance measurement tool);
21 and
22 ''(iii) the 'Health Outcomes Survey'
23 (also known as 'HOS') (or an appropriate
24 successor performance measurement tool);
25 and

1 "(B) other data collected by the State.
2 "(5) REPORTS.—
3 "(A) IN GENERAL.—Each State shall col-
4 lect, analyze, and report to the Secretary, at a
5 frequency and in a manner to be established by
6 the Secretary, data described in paragraph (4)
7 that permit the Secretary to monitor the State's
8 performance relative to the chronic care per-
9 formance targets established under paragraph
10 (3).
11 "(B) REVIEW AND VERIFICATION.—The
12 Secretary may review the data collected by the
13 State under subparagraph (A) to verify the
14 State's analysis of such data with respect to the
15 performance targets under paragraph (3).
16 "(6) AMOUNT OF BONUS PAYMENTS.—
17 "(A) IN GENERAL.—Subject to subpara-
18 graphs (B) and (C), with respect to each cat-
19 egory of Medicaid beneficiaries, in the case of
20 a State that the Secretary determines, based on
21 the chronic care performance targets set under
22 paragraph (3) for a reform year for such cat-
23 egory, performs—
24 "(i) in the top five States in such cat-
25 egory, subject to subparagraph (C)(ii), the

1 amount of the bonus for each quarter in
2 the succeeding reform year shall be 10 per-
3 cent of the payment amount otherwise paid
4 to the State under subsection (a) for indi-
5 viduals enrolled under the plan within such
6 category;
7 "(ii) in the next five States in such
8 category, subject to subparagraph (C)(ii),
9 the amount of the bonus for each such
10 quarter shall be 5 percent of the payment
11 amount otherwise paid to the State under
12 subsection (a) for individuals enrolled
13 under the plan within such category;
14 "(iii) in the next five States in such
15 category, subject to clauses (i) and (iii) of
16 subparagraph (C), the amount of the
17 bonus for each such quarter shall be 3 per-
18 cent of the payment amount otherwise paid
19 to the State under subsection (a) for indi-
20 viduals enrolled under the plan within such
21 category;
22 "(iv) in the next five States in such
23 category, subject to clauses (i) and (iii) of
24 subparagraph (C), the amount of the
25 bonus for each such quarter shall be 2 per-

1 cent of the payment amount otherwise paid
2 to the State under subsection (a) for indi-
3 viduals enrolled under the plan within such
4 category; and
5 "(v) in the next five States in such
6 category, subject to clauses (i) and (iii) of
7 subparagraph (C), the amount of the
8 bonus for each such quarter shall be 1 per-
9 cent of the payment amount otherwise paid
10 to the State under subsection (a) for indi-
11 viduals enrolled under the plan within such
12 category.
13 "(B) AGGREGATE ANNUAL LIMIT FOR
14 EACH CATEGORY OF MEDICAID BENE-
15 FICIARIES.—
16 "(i) IN GENERAL.—In no case may
17 the aggregate amount of bonuses under
18 this subsection for quarters in a reform
19 year for a category of Medicaid bene-
20 ficiaries exceed the limit specified in clause
21 (ii) for the reform year.
22 "(ii) LIMIT.—The limit specified in
23 this clause—
24 "(I) for the second reform year is
25 equal to $250,000,000; or

1 "(II) for a subsequent reform
2 year is equal to the limit specified in
3 this clause for the previous reform
4 year increased by the per beneficiary
5 percentage increase determined under
6 paragraph (1)(E) of subsection (c).
7 "(C) LIMITATION AND PRORATION OF BO-
8 NUSES BASED ON APPLICATION OF AGGREGATE
9 LIMIT.—
10 "(i) NO BONUS FOR THIRD OR SUBSE-
11 QUENT TIERS UNLESS AGGREGATE LIMIT
12 NOT REACHED ON FIRST TWO TIERS.—No
13 bonus shall be payable under clause (iii),
14 (iv), or (v) of subparagraph (A) for a cat-
15 egory of Medicaid beneficiaries for a quar-
16 ter in a reform year unless the aggregate
17 amount of bonuses under clauses (i) and
18 (ii) of such subparagraph for such category
19 and reform year is less than the limit spec-
20 ified in subparagraph (B)(ii) for the re-
21 form year.
22 "(ii) PRORATION FOR FIRST TWO
23 TIERS.—If the aggregate amount of bo-
24 nuses under clauses (i) and (ii) of subpara-
25 graph (A) for a category of Medicaid bene-

1 ficiaries for quarters in a reform year ex-
2 ceeds the limit specified in subparagraph
3 (B)(ii) for the reform year, the amount of
4 each such bonus shall be prorated in a
5 manner so the aggregate amount of such
6 bonuses is equal to such limit.

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

1 "(g) STATE OPTION FOR RECEIVING MEDICARE PAY-
2 MENTS FOR FULL-BENEFIT DUAL ELIGIBLE INDIVID-
3 UALS.—
4 "(1) IN GENERAL.—Under this subsection a
5 State may elect for quarters beginning on or after
6 the implementation date in a reform year to receive
7 payment from the Secretary under paragraph (3).
8 As a condition of receiving such payment, the State
9 shall agree to provide to full-benefit dual eligible in-
10 dividuals eligible for medical assistance under the
11 State plan—
12 "(A) the medical assistance to which such
13 eligible individuals would otherwise be entitled
14 under this title; and
15 "(B) any items and services which such eli-
16 gible individuals would otherwise receive under
17 title XVIII.
18 "(2) PROVIDER PAYMENT REQUIREMENT.—
19 "(A) IN GENERAL.—A State electing the
20 option under this subsection shall provide pay-
21 ment to health care providers for the items and
22 services described under paragraph (1)(B) at a
23 rate that is not less than the rate at which pay-
24 ments would be made to such providers for such
25 items and services under title XVIII.

1 "(B) FLEXIBILITY IN PAYMENT METH-
2 ODS.—Nothing in subparagraph (A) shall be
3 construed as preventing a State from using al-
4 ternative payment methodologies (such as bun-
5 dled payments or the use of accountable care
6 organizations (as such term is used in section
7 1899)) for purposes of making payments to
8 health care providers for items and services pro-
9 vided to dual eligible individuals in the State
10 under the option under this subsection.
11 "(3) PAYMENTS TO STATES IN LIEU OF MEDI-
12 CARE PAYMENTS.—With respect to a full-benefit
13 dual eligible individual, in the case of a State that
14 elects the option under paragraph (1) for quarters in
15 a reform year—
16 "(A) the Secretary shall not make any pay-
17 ment under title XVIII for items and services
18 furnished to such individual for such quarters;
19 and
20 "(B) the Secretary shall pay to the State,
21 in addition to the amounts paid to such State
22 under subsection (a), the amount that the Sec-
23 retary would, but for this subsection, otherwise
24 pay under title XVIII for items and services

1 furnished to such an individual in such State
2 for such quarters.
3 "(4) FULL-BENEFIT DUAL ELIGIBLE INDI-
4 VIDUAL DEFINED.—In this subsection, the term
5 'full-benefit dual eligible individual' means an indi-
6 vidual who meets the requirements of section
7 1935(c)(6)(A)(ii).
8 "(h) AUDITS.—The Secretary shall conduct such au-
9 dits on the number and classification of Medicaid bene-
10 ficiaries under such subsections and expenditures under
11 this section as may be necessary to ensure appropriate
12 payments under this section.
13 "(i) TREATMENT OF WAIVERS.—
14 "(1) NO IMPACT ON CURRENT WAIVERS.—In
15 the case of a waiver of requirements of this title pur-
16 suant to section 1115 or other law that is in effect
17 as of the date of the enactment of this section, noth-
18 ing in this section shall be construed to affect such
19 waiver for the period of the waiver as approved as
20 of such date.
21 "(2) APPLICATION OF BUDGET NEUTRALITY TO
22 SUBSEQUENT WAIVERS AND RENEWALS TAKING SEC-
23 TION INTO ACCOUNT.—In the case of a waiver of re-
24 quirements of this title pursuant to section 1115 or
25 other law that is approved or renewed after the date

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

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

9 "(k) DEFINITIONS.—In this section:

10 "(1) IMPLEMENTATION DATE.—The term 'im-
11 plementation date' means—

12 "(A) July 1, 2017, if this section is en-
13 acted on or before July 1, 2016; or

14 "(B) July 1, 2018, if this section is en-
15 acted after July 1, 2016.

16 "(2) REFORM YEARS.—

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

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

22 "(C) The terms 'second', 'third', and suc-
23 cessive similar terms mean, with respect to a
24 reform year, the second, third, or successive re-

1 form year, respectively, succeeding the first re-
2 form year.''.
3 (b) CONFORMING AMENDMENTS.—
4 (1) CONTINUED APPLICATION OF CLAWBACK
5 PROVISIONS.—
6 (A) CONTINUED APPLICATION.—Sub-
7 sections (a) and (c)(1)(C) of section 1935 of
8 such Act (42 U.S.C. 1396u–5) are each amend-
9 ed by inserting ''or 1903A(a)'' after ''1903(a)''.
10 (B) TECHNICAL AMENDMENT.—Section
11 1935(d)(1) of the Social Security Act (42
12 U.S.C. 1396u–5(d)(1)) is amended by inserting
13 ''except as provided in section 1903A(g)'' after
14 ''any other provision of this title''.
15 (2) PAYMENT RULES UNDER SECTION 1903.—
16 (A) Section 1903(a) of such Act (42
17 U.S.C. 1396b(a)) is amended, in the matter be-
18 fore paragraph (1), by inserting ''and section
19 1903A'' after ''except as otherwise provided in
20 this section''.
21 (B) Section 1903(d) of such Act (42
22 U.S.C. 1396b(d)) is amended—
23 (i) in paragraph (1), by inserting
24 ''and under section 1903A'' after ''sub-
25 sections (a) and (b)'';

1 (ii) in paragraph (2)—
2 (I) in subparagraph (A), by in-
3 serting ''or section 1903A'' after ''was
4 made under this section''; and
5 (II) in subparagraph (B), by in-
6 serting ''or section 1903A'' after
7 ''under subsection (a)'';
8 (iii) in paragraph (4)—
9 (I) by striking ''under this sub-
10 section'' and inserting '', with respect
11 to this section or section 1903A,
12 under this subsection''; and
13 (II) by striking ''under this sec-
14 tion'' and inserting ''under the respec-
15 tive section''; and
16 (iv) in paragraph (5), by inserting ''or
17 section 1903A'' after ''overpayment under
18 this section''.
19 (3) CONFORMING WAIVER AUTHORITY.—Section
20 1115(a)(2)(A) of the Social Security Act (42 U.S.C.
21 1315(a)(2)(A)) is amended by striking ''or 1903''
22 and inserting ''1903, or 1903A''.
23 (4) REPORT ON ADDITIONAL CONFORMING
24 AMENDMENTS NEEDED.—Not later than 6 months
25 after the date of the enactment of this Act, the Sec-

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

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

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

12 (a) IN GENERAL.—Section 1867 of the Social Secu-
13 rity Act (42 U.S.C. 1395dd) is amended—
14 (1) in subsection (d), by adding at the end the
15 following new paragraph:
16 "(5) ENFORCEMENT WITH RESPECT TO EXCES-
17 SIVE CHARGES.—A hospital, physician, or other enti-
18 ty that violates the requirements of subsection (j)(1)
19 with respect to the furnishing of items and services
20 is subject to a civil money penalty of not more than
21 $25,000 for each such violation. The provisions of
22 section 1128A (other than subsections (a) and (b))
23 shall apply to a civil money penalty under this para-
24 graph in the same manner as such provisions apply

1 with respect to a penalty or proceeding under section
2 1128A(a).''; and
3 (2) by adding at the end the following new sub-
4 section:
5 ''(j) PROTECTIONS AGAINST EXCESSIVE OUT-OF-
6 NETWORK CHARGES FOR EMERGENCY SERVICES.—
7 ''(1) IN GENERAL.—If items or services to
8 screen or treat an emergency medical condition are
9 furnished under this section in a participating hos-
10 pital with respect to an individual and the individual
11 has not, directly or through a health insurance
12 issuer, group health plan, or other third party, nego-
13 tiated a payment rate for such items and services,
14 subject to paragraph (2), the charges imposed for
15 such items and services may not be in excess of the
16 following:
17 ''(A) PHYSICIANS' AND OTHER PROFES-
18 SIONAL SERVICES.—For physicians' services or
19 services of a health care provider to which sec-
20 tion 223(e)(9) of the Internal Revenue Code of
21 1986 applies (and including drugs and
22 biologicals furnished in conjunction with and
23 billed as part of such services), the lesser of—
24 ''(i) the cash price for such services
25 posted pursuant to such section; or

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

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

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

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

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

1 "(i) twice the acquisition cost to the
2 hospital or other provider for the dose in-
3 volved; or
4 "(ii) the acquisition cost to the hos-
5 pital or other provider plus $250.
6 The dollar amount in clause (ii) shall be in-
7 creased from year to year (beginning with the
8 year after the first year in which this subsection
9 applies) by the same percentage as the percent-
10 age increase in the consumer price index for all
11 urban consumers (all items; U.S. city average)
12 for the year involved (as determined by the Sec-
13 retary). Any such dollar amount as so increased
14 that is not a multiple of $5 shall be rounded to
15 the nearest multiple of $5 (or, if a multiple of
16 $2.50, to the next highest multiple of $5).
17 "(D) OTHER ITEMS AND SERVICES.—For
18 any other items or services, the lesser of—
19 "(i) the cash price for such items and
20 services posted pursuant to section
21 223(e)(9) of the Internal Revenue Code of
22 1986; or
23 "(ii) 110 percent of the payment basis
24 that would be applicable to payment for
25 such items and services under this title in

1 the case of an individual entitled to bene-
2 fits under part A and enrolled under part
3 B.
4 "(2) SPECIAL RULE FOR ITEMS AND SERVICES
5 FURNISHED AS A BUNDLE.—In the case of items
6 and services for which there is a single price for a
7 group or bundle of such items and services, the max-
8 imum charge permitted under paragraph (1) may
9 not exceed the lesser of—
10 "(A) the price charged for such bundled
11 services; or
12 "(B) the aggregate of the maximum
13 charges permitted under paragraph (1) with re-
14 spect to items and services included in such
15 bundle.".
16 (b) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to charges imposed for items and
18 services furnished on or after January 1, 2017.
19 **SEC. 502. PUBLISHING OF CASH PRICE FOR CARE PAID**
20 **THROUGH HEALTH SAVINGS ACCOUNTS.**
21 (a) HEALTH SAVINGS ACCOUNTS.—Section 223(f) of
22 the Internal Revenue Code of 1986 is amended by adding
23 at the end the following new paragraph:
24 "(9) CASH PRICE TRANSPARENCY REQUIRED
25 FOR PAYMENTS TO HEALTH CARE PROVIDERS.—

1 "(A) IN GENERAL.—A payment to a health
2 care provider with respect to the furnishing of
3 health care items and services by such provider
4 shall not be treated as a qualified medical ex-
5 pense unless health care provider provides for
6 continuing disclosure (such as through posting
7 on a publicly accessible website) of the cash
8 price the health care provider charges for the
9 furnishing of such items and services.
10 "(B) FORM OF DISCLOSURE.—The disclo-
11 sure of prices under this subsection shall be in
12 a form and manner specified by the Secretary
13 of Health and Human Services, in consultation
14 with the Secretary, and shall be designed—
15 "(i) to establish a single price for re-
16 lated items and services in a manner simi-
17 lar to the manner in which pricing and
18 payment for such items and services is pro-
19 vided under the Medicare program under
20 title XVIII of the Social Security Act, and
21 "(ii) to make it easy for consumers to
22 compare the prices for similar items and
23 services furnished by different providers.
24 "(C) FAILURE TO FURNISH SERVICES OR
25 CHARGE IN EXCESS OF STATED PRICE.—A

1 health care provider shall be treated as not
2 meeting the requirement of subparagraph (A),
3 in the case of items and services for which the
4 provider is disclosing a cash price, if the pro-
5 vider—
6 "(i) refuses to furnish such items or
7 services at the price listed, or
8 "(ii) charges more than the price list-
9 ed for the furnishing of the items and serv-
10 ices.".
11 (b) ROTH HSA.—Section 530A(c)(4) of such Code,
12 as added by this Act, is amended by adding at the end
13 the following new subparagraph:
14 "(E) Section 223(f) (relating to cash price
15 transparency required for payments to health
16 care providers).".
17 (c) ENFORCEMENT.—If the Secretary of Health and
18 Human Services determines that a health care provider
19 has not provided for continuing disclosure of the cash
20 price of health care provider charges under section
21 223(f)(9) of the Internal Revenue Code of 1986, the Sec-
22 retary may instruct the Secretary of the Treasury that
23 payments made to such provider shall be not treated, for
24 purposes of section 223 of the Internal Revenue Code of

1 1986, as an amount used for a qualified medical expense
2 for a period of not to exceed 1 year.
3 (d) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to taxable years beginning after
5 December 31, 2016.

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

8 (a) WAIVING NATIONAL RESTRICTIONS ON PHYSI-
9 CIAN-OWNED FACILITIES.—Section 1877 of the Social Se-
10 curity Act (42 U.S.C. 1395nn) is amended by adding at
11 the end the following new subsection:
12 ''(j) WAIVER AUTHORITY.—A physician or other enti-
13 ty may apply to the Secretary to waive any provision of
14 this section and the Secretary may waive such provision
15 with respect to such physician or entity if the Secretary
16 determines that such waiver would—
17 ''(1) increase competition within the health care
18 market;
19 ''(2) reduce the costs of health care; and
20 ''(3) increase the quality of health care.''.
21 (b) REMOVING CERTAIN STATE AND LOCAL LICEN-
22 SURE OR CERTIFICATION RESTRICTIONS.—
23 (1) APPLICATION FOR WAIVER OF RESTRIC-
24 TIONS.—An individual who is required to be licensed
25 or certified by a State as a condition of furnishing

1 items or services as a health care professional (as
2 defined by the Secretary of Health and Human
3 Services) may submit to the Secretary an application
4 to waive any condition of such licensure or certifi-
5 cation.
6 (2) STANDARD.—The Secretary may grant a
7 waiver submitted under paragraph (1) if the Sec-
8 retary determines such waiver would—
9 (A) increase competition within the health
10 care market;
11 (B) reduce the costs of health care; and
12 (C) increase the quality of health care.
13 (3) PREEMPTION.—In the case of a health care
14 professional granted a waiver under paragraph (2),
15 any requirement with respect to which such waiver
16 is granted is preempted to the extent specified in
17 such waiver.