PATIENT FREEDOM ACT

Better Choices for Affordable Health Care

The Patient Freedom Act (PFA) of 2017 takes power from Washington and returns it to state capitols and individuals in order to expand access to health care for all Americans, especially those with pre-existing conditions. This proposal gives patients the power by making enrollment easy, requiring price transparency, eliminating mandates, and transferring power over insurance back to patients and state governments.

Repeals: This proposal repeals 5 burdensome federal mandates under Obamacare: the individual mandate, the employer mandate, Essential Health Benefits, actuarial value requirements, and age band requirements.

Keeps: This proposal keeps essential consumer protections, including guaranteed issue, guaranteed renewability, no annual or lifetime limits, dependent coverage through age 26, and prohibiting pre-existing condition exclusions, and prohibiting discrimination based on health status

State Option: After repeal, states will have one of three options:

1. Better Choice Plan—State determines its own insurance regulations and receives funding equal to 95% of Obamacare tax credits and Obamacare Medicaid expansion funding in the form of either a per capita block grant or an advanceable, refundable tax credits. Tax credits will be age-adjusted and means tested.
2. Design an Alternative Solution without Federal Assistance—This option would return power to the states to design and regulate insurance markets that work for their specific populations, without any federal assistance.
3. Maintain current trajectory—State legislature votes to reimpose mandates, exchange plans, and federal premium and cost-sharing subsidies. States that chose this option will only receive funds in an equal manner to those states that choose the Better Choice Plan.

Eligible Individuals: This proposal provides financial assistance to legal residents of the United States not receiving income tax benefits from having employer sponsored insurance, and who do not have Medicare, Medicaid or other government funded health care. This goal is to provide roughly the same federal benefit that those with employer-sponsored insurance receive to those who do not have employer sponsored insurance.

Funding: Each state will receive the funds that it would have received under Obamacare if 95% of everyone eligible for subsidies enrolled; in addition, the state will receive the money that would have paid for a Medicaid expansion. If states choosing this option have already expanded Medicaid, the state could either keep its Medicaid expansion or convert it to subsidies to help individuals purchase private insurance.

Distribution of Funds: The money will be deposit directly into an individual's Roth HSA to assist in the purchase of health care. States will have the option to either receive the total sum of money for administration by the state, or to have the Federal government directly administer and give a tax credit to qualifying individuals. States will have the option to auto-enroll individuals. If auto-enrollment is selected, individuals will be allowed to opt-out of coverage. The auto-enroll feature eliminates the need for either an individual or employer mandate.

***Benefit Design*:** All individuals receiving the health credit would receive a Roth Health Savings Account (HSA), a high-deductible health plan (HDHP), and a basic pharmacy benefit plan. The only mandated benefits would be those required of ERISA plans. There will be continuous coverage protections, as well as the essential consumer protections listed above. Beyond that, regulation of the insurance market reverts to the state.

***Expand Health Savings Accounts*:** On a federal level, HSA law will change to allow HSAs to pay for health insurance premiums, for family members to pool dollars to pay for increased expenses, and to allow insurance companies to offer HSA/HDHP policies, which cover all inpatient services.

***Price Transparency*:** To make HSAs more useful, providers receiving payment for HSAs will be required to publish "cash prices" for services paid for with an HSA or with cash. In order to protect those who do need emergency services, the PFA calls for limited out of network surcharges for emergency medical services paid for with an HSA.

The Patient Freedom Act :
The Better Choice to Obamacare

Gives patients the power by:

●making enrollment easy ● requiring price transparency ● eliminating mandates ● transferring power over insurance back to patients and state governments

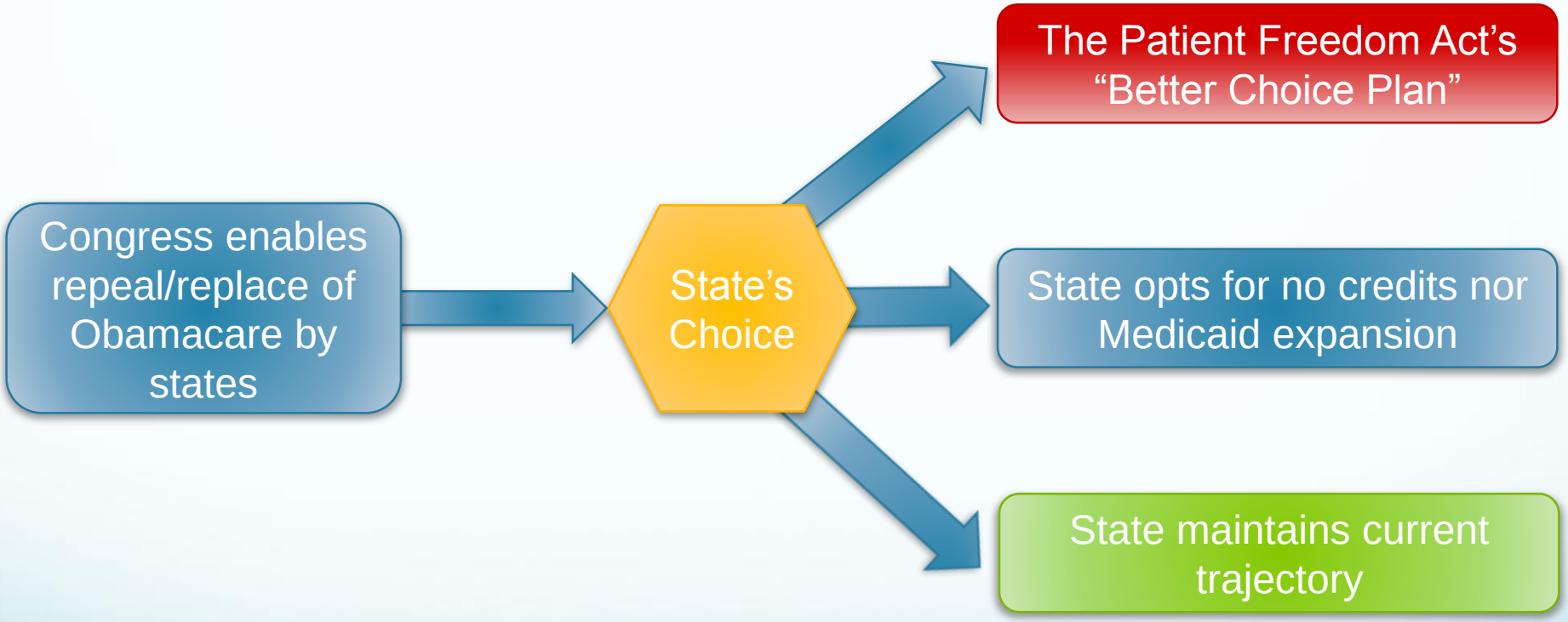
Republicans must maintain three values heading into 2017:

1) Reduce the number of uninsured Americans

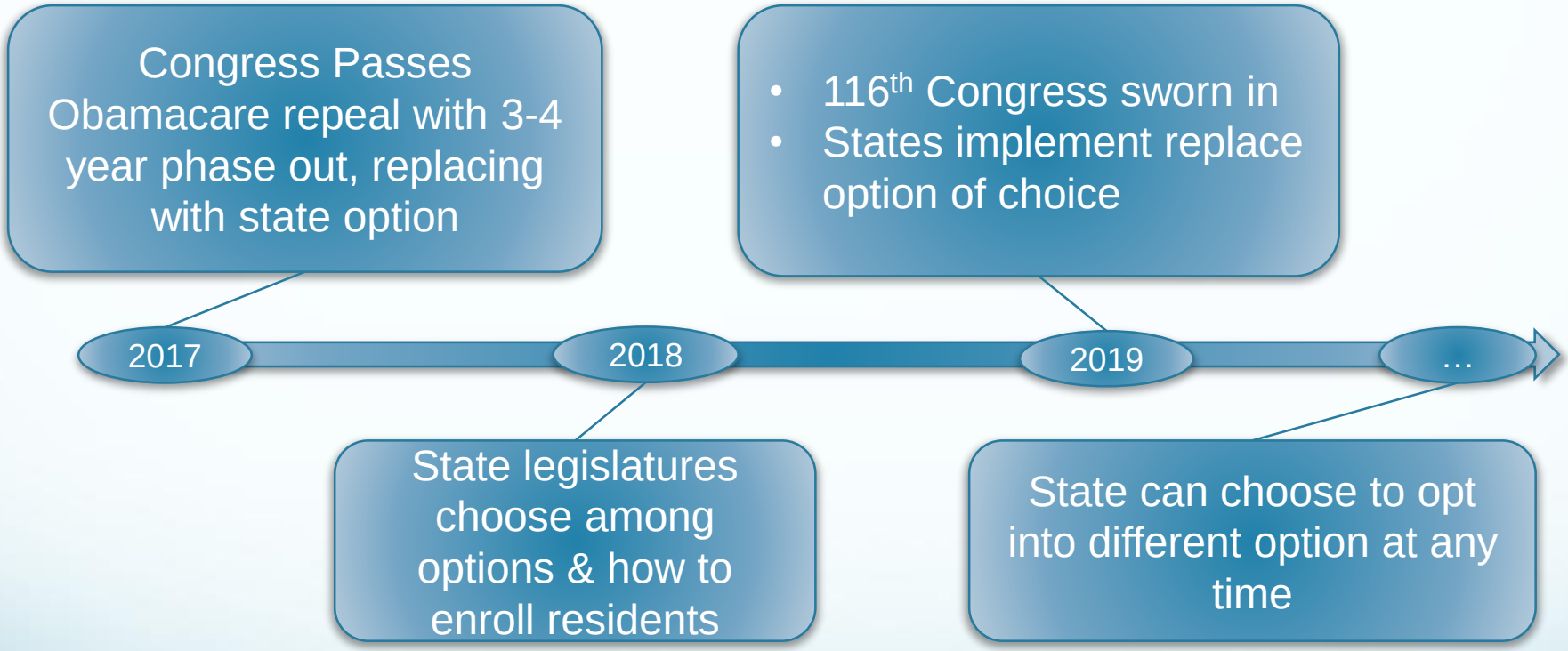
2) Ensure that no one loses health care coverage

3) Respect states' rights, giving states the flexibility to choose a system that works for them. Include states in the repeal and replace process

Framework:


Congress enables repeal/replace of Obamacare by states
State's Choice
The Patient Freedom Act's "Better Choice Plan"
State opts for no credits nor Medicaid expansion
State maintains current trajectory

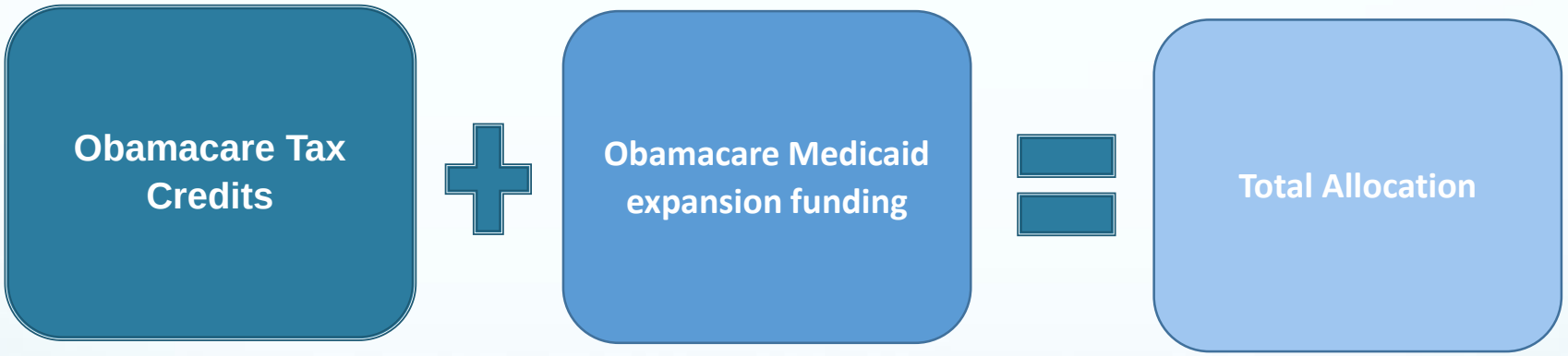
Replace Timeline



Lower Costs by… Repealing Federal Mandates

	Obamacare	Better Choice Plan
Individual Mandate Penalty	**YES**	**NO**
Employer Mandate Penalty	**YES**	**NO**
Federal Essential Health Benefits Mandates	**YES**	**NO**
Federal Actuarial Value Mandates	**YES**	**NO**
Federal 3-1 Age Band Requirement	**YES**	**NO**

Money Made Available to States



Enrollment

- State could automatically enroll all eligible Americans with ability to opt-out by the individual.
- Similar to automatic Medicare enrollment at age 65.
- Could achieve 95% enrollment, restoring stability and actuarial soundness to insurance market through the law of big numbers.

Funding Goes Directly to the PATIENT

States: no state exchange & may choose:

1) Per Capita Block Grant Funding

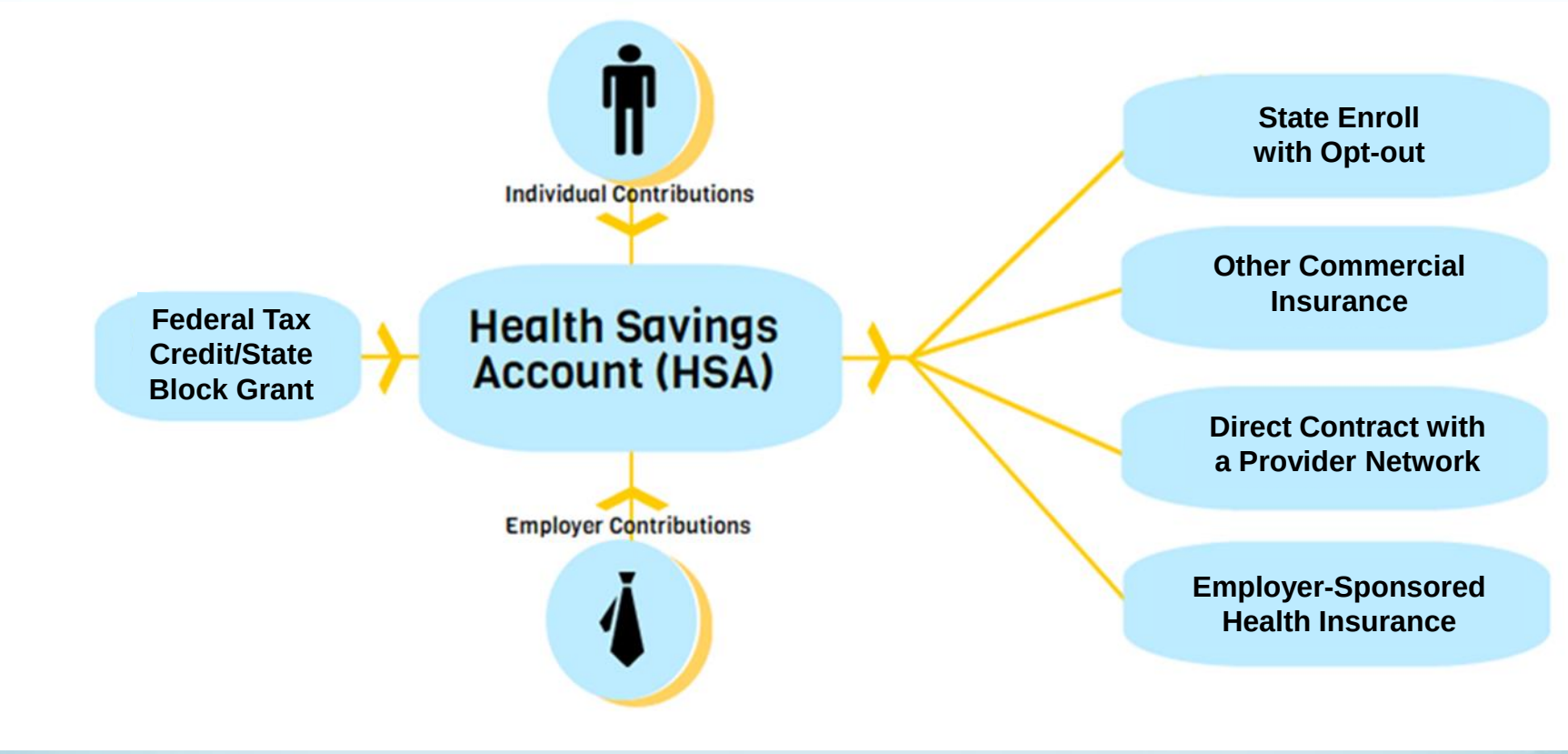
or

2) Federal Tax Credit Funding

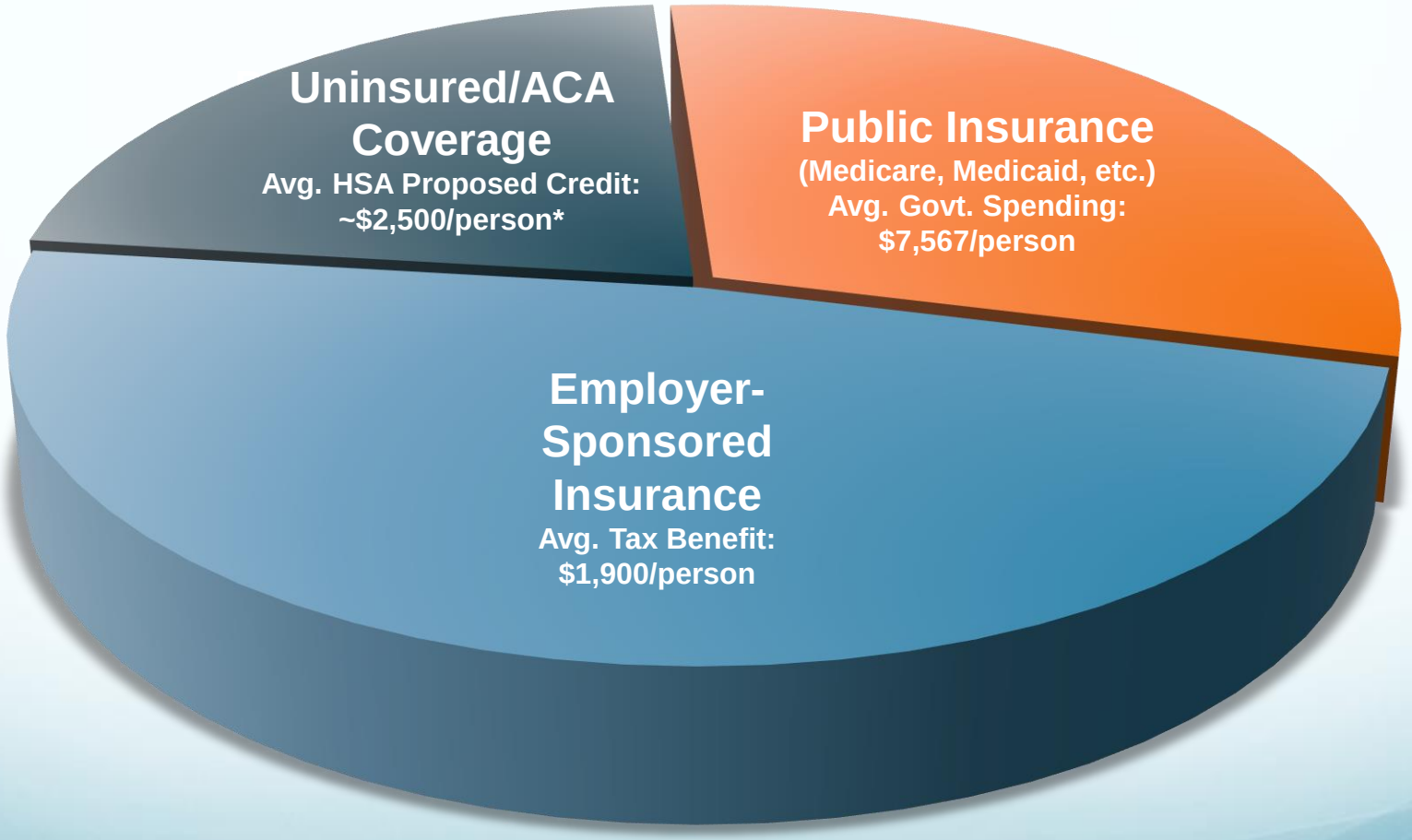
but

A federal or state tax credit goes to patient to purchase health coverage

Patients use HSA to Purchase Health Coverage



Lower Costs by… Equalizing Tax Treatment



*Tax credit is adjusted for age and geography

Patients have the Power of…

Portability, Protection and Price Transparency

Continuous coverage protects those with pre-existing conditions

Patients can move between health insurance plans without penalty during open enrollment

Providers must publish cash price for services reimbursed from a HSA

115TH CONGRESS
1ST SESSION

S. _____

To improve patient choice by allowing States to adopt market-based alternatives to the Affordable Care Act that increase access to affordable health insurance and reduce costs while ensuring important consumer protections and improving patient care.

IN THE SENATE OF THE UNITED STATES

Mr. CASSIDY (for himself, Ms. COLLINS, Mrs. CAPITO, and Mr. ISAKSON) introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To improve patient choice by allowing States to adopt market-based alternatives to the Affordable Care Act that increase access to affordable health insurance and reduce costs while ensuring important consumer protections and improving patient care.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Patient Freedom Act of 2017''.

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

Sec. 1. Short title; table of contents.

TITLE I—HEALTH REFORM

Sec. 100. Definitions.

Subtitle A—Insurance Market Reform

Sec. 101. Ending the ''one size fits all'' ACA approach; continuing consumer protection policies by covering adult children, protecting individuals with preexisting conditions, and not applying lifetime or annual limits.
Sec. 102. State health insurance options.
Sec. 103. State alternative option.
Sec. 104. Computation of monthly Roth HSA deposit amount for deposit qualifying residents.
Sec. 105. State options for improved access to health insurance coverage in each State.
Sec. 106. State flexibility in ensuring orderly health insurance market outside of an Exchange.
Sec. 107. Expanded access and patient protections.
Sec. 108. Application of health savings accounts in relation to Medicaid.

Subtitle B—Provider Price Transparency

Sec. 121. Ensuring access to emergency services without excessive charges for out-of-network services.

TITLE II—REFORM OF TAX PROVISIONS RELATING TO HEALTH CARE

Subtitle A—Health Savings Accounts

Sec. 201. Transition to non-deductible HSAs.
Sec. 202. Treatment of direct primary care.
Sec. 203. Treatment of HSA after death of account beneficiary.

Subtitle B—Health Care Tax Credits

Sec. 211. Limited application of PPACA health premium credit.
Sec. 212. New Roth HSA credit.

TITLE I—HEALTH REFORM

SEC. 100. DEFINITIONS.

In this title:

(1) PATIENT-GRANT ELECTING STATE.—The term ''patient-grant electing State'' means an electing State that specifies under section 103(a)(3)(B) that it will carry out section 103(b) itself (and not

to have section 103(b) carried out by means of the credit under section 36C of the Internal Revenue Code of 1986).

(2) BUDGET NEUTRAL.—The term ''budget neutral'' with respect to expenditures provided for in this Act, means the same amount of expenditures as are provided for under the Patient Protection and Affordable Care Act (Public Law 111-148).

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

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

(5) DEFAULT HEALTH INSURANCE COVERAGE.—The term ''default health insurance coverage'' has the meaning given such term in section 107(c)(2).

(6) DEPOSIT QUALIFYING RESIDENT.—The term ''deposit qualifying resident'' has the meaning given such term in section 103(b)(2).

(7) ELECTING STATE.—The term ''electing State'' means a State that elects under section 102(a)(2) the alternative option described in section 103.

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

(9) HEALTH SAVINGS DEPOSIT.—The term ''health savings deposit'' means a deposit made into a Roth HSA pursuant to section 103.

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

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

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

(13) QUALIFIED HEALTH PLAN COVERAGE.—The term ''qualified health plan coverage'' means, with respect to residents of a State, health insurance

coverage that meets applicable standards under State law, which standards need not be the same as that previously required of qualified health plans under title I of PPACA, and includes a high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) and includes coverage under a group health plan.

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

(15) ROTH HEALTH SAVINGS ACCOUNT; ROTH HSA.—The terms ''Roth health savings account'' and ''Roth HSA'' mean a Roth HSA established under section 530A of the Internal Revenue Code of 1986.

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

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

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

Subtitle A—Insurance Market Reform

SEC. 101. ENDING THE "ONE SIZE FITS ALL" ACA APPROACH; CONTINUING CONSUMER PROTECTION POLICIES BY COVERING ADULT CHILDREN, PROTECTING INDIVIDUALS WITH PREEXISTING CONDITIONS, AND NOT APPLYING LIFETIME OR ANNUAL LIMITS.

(a) IN GENERAL.—Subject to subsections (b) and (c), title I of the Patient Protection and Affordable Care Act (including the amendments made by such title) shall not apply (and the provisions of law amended by such title are restored as if such title had not been enacted) in the case of any State that does not have in effect the election described in section 102(a)(1).

(b) CONTINUATION OF POLICIES FOR EXTENSION OF DEPENDENT COVERAGE FOR ADULT CHILDREN AND PROHIBITION OF LIFETIME AND ANNUAL COVERAGE LIMITS; PRESERVATION OF BLACK LUNG BENEFITS.—

(1) PUBLIC HEALTH SERVICE ACT PROVISIONS.—Notwithstanding subsection (a), the following sections of the Public Health Service Act, that were added or amended by subtitles A and C of title I of PPACA, shall continue to apply to group

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

(A) NO LIFETIME OR ANNUAL LIMITS.—Section 2711 (relating to no lifetime or annual limits), except in the case of limited benefit insurance.

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

(C) PROHIBITING PRE-EXISTING CONDITION EXCLUSIONS.—Section 2704 (relating to prohibition on preexisting conditions).

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

(E) PRESERVATION OF PREVENTIVE SERVICE COVERAGE.—Section 2713 (relating to coverage of preventive health services), if employers do not contribute to the individual's Roth HSA.

(2) PRESERVATION OF NON-DISCRIMINATION IN HEALTH CARE.—Subsection (a) shall not apply with

respect to section 1557 of title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18116).

(3) PRESERVATION OF COVERAGE OF MENTAL HEALTH SERVICES, AND APPLICABILITY OF MENTAL HEALTH PARITY.—For serious mental illness, serious emotional disturbance, and substance use disorder, subsection (a) shall not apply with respect to section 1302(b)(1)(E) of title I of the Patient Protection and Affordable Care Act (relating to coverage of mental health and substance use treatment at limited cost sharing) (42 U.S.C. 18022(b)(1)(E)). Section 2726 of the Public Health Service Act shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance coverage and group health plans.

(4) PRESERVATION OF BLACK LUNG BENEFITS FOR COAL MINERS.—Subsection (a) shall not apply with respect to section 1556 of title I of the Patient Protection and Affordable Care Act (amending the Black Lung Benefits Act).

(5) PRESERVATION OF STATE INNOVATIONS.—Subsection (a) shall not apply with respect to section 1332 of title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18052).

(c) CONTINUATION OF FEDERAL EXCHANGES.—Subsection (a) shall not apply with respect to Federal Exchanges established pursuant to section 1321(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(c)) and such Exchanges shall continue to operate as provided for by the Secretary.

SEC. 102. STATE HEALTH INSURANCE OPTIONS.

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

(1) CONTINUING IMPLEMENTATION OF PPACA.—The State continuing—

(A) the Federal premium and cost-sharing subsidies for coverage offered under title I of PPACA (and the amendments made thereby), reduced for qualified residents of such State for any year by the amount (if any) by which such subsidies would exceed the amount of contributions that would have been made under section 103(b) to all such residents for such year if the State had elected the option under paragraph (3); and

(B) all other requirements under such title.

(2) ESTABLISHING NEW STATE AND MARKET-BASED ALTERNATIVE, WITH ALTERNATIVE PER BENEFICIARY FEDERAL DEPOSIT SYSTEM.—The State implementing the alternative option described in section 103, which includes—

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

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

(3) REJECTION OF PPACA.—The State rejecting title I of PPACA (and the amendments made thereby), except as otherwise required in this title.

If a State fails to make an election described in this subsection during the 1-year period beginning on the date of enactment of this Act, the State shall be deemed to have made the election described in paragraph (2). A State may, through written notice to the Secretary, change an election previously made under this subsection.

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

1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)), except that a State that elects not to provide medical assistance to individuals under such section may make such individuals deposit qualifying residents under this title.

SEC. 103. STATE ALTERNATIVE OPTION.

(a) IN GENERAL.—In the case of a State that elects under section 102(a)(2) the alternative option under this section, subject to subsection (d) and section 107, the following shall apply:

(1) ELIMINATION OF INDIVIDUAL AND EMPLOYER SHARED RESPONSIBILITY FOR HEALTH CARE TAX REQUIREMENTS FOR RESIDENTS AND EMPLOYEES IN STATE.—The individual and employer health care responsibilities under the amendments made by title I of PPACA (including under sections 5000A and 4980H of the Internal Revenue Code of 1986) shall no longer apply pursuant to section 101 with respect to individuals who are residents of such State and with respect to individuals who are employed in such State, respectively.

(2) MODIFICATION OF INSURANCE REQUIREMENTS.—Except as specifically provided in this title, the requirements under title I of PPACA (including amendments made by such title) relating to health

insurance coverage offered in the State shall not apply except to the extent specified by the State.

(3) NEW DEPOSIT SYSTEM THROUGH FUNDING ROTH HSAS.—

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

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

(4) ADDITIONAL AMOUNTS FOR POPULATION HEALTH INITIATIVES FOR STATE ADMINISTERED ROTH HSA DEPOSIT SYSTEM.—A patient-grant electing State (as defined in section 100(1)) is entitled to receive additional funding under subsection (c) for population health initiatives.

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

(1) IN GENERAL.—The subsidies described in subsection (a)(3) for an electing State shall be furnished for each deposit qualifying resident through the deposit of a contribution into a Roth HSA of the individual in the amount determined under section 104. For purposes of the Internal Revenue Code of 1986, the amount of any contribution to a Roth HSA made under this paragraph shall be included in the gross income of the individual for whose benefit the Roth HSA was established.

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

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

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

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

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

(3) PAYMENT ADMINISTRATION.—

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

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

(B) FEDERAL.—In the case of a State electing to carry out this subsection other than through the State, subsidies described in subsection (a)(3) shall be provided through a refundable tax credit under section 36C of the Internal Revenue Code of 1986.

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

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

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

each deposit qualifying resident who does not otherwise have a Roth HSA;

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

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

(c) POPULATION HEALTH INITIATIVE FUNDING.—

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

(2) USE OF FUNDS.—Amounts paid to a State under paragraph (1) may only be used for population health initiatives (as defined by the Secretary).

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

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

SEC. 104. COMPUTATION OF MONTHLY ROTH HSA DEPOSIT AMOUNT FOR DEPOSIT QUALIFYING RESIDENTS.

(a) COMPUTATION.—

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

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

(B) for income under subsection (d).

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

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

for qualifying individuals shall remain budget neutral.

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

(b) COMPUTATION OF UNADJUSTED AVERAGE PER CAPITA ANNUAL AMOUNT.—

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

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

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

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

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

able year ending with such year, if applicable). The Secretary shall, in conjunction with the Actuary, ensure such changes to the amount of deposit for qualifying individuals shall remain budget neutral.

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

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

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

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

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

(i) 95 percent of the Secretary's estimate of the total payments that would have been made (assuming the existence of

a State-established Exchange in the State) under section 36B of the Internal Revenue Code of 1986 and under section 1402 of PPACA with respect to all qualified residents in the year (or taxable year ending with such year, if applicable); and

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

(3) BUDGET NEUTRAL ADJUSTMENT IN PAYMENTS TO TAKE INTO ACCOUNT ELECTION OF HIGHER DEPOSITS TO MAINTAIN ACA SUBSIDY LEVELS.—If a State makes the election described in subsection (a)(3) with respect to providing higher deposit amounts for certain individuals described in such subsection, then the Secretary shall adjust the aver-

age per capita annual amount under paragraph (1) or (2), as applicable to the State, by—

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

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

The Secretary shall, in conjunction with the Actuary, ensure changes, as outlined in this subsection, to the amount of deposit for qualifying individuals shall remain budget neutral.

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

(A) reducing the amount described in paragraph (1)(B) (or, if applicable, paragraph (2)(B)(i)) by an amount equal to 95 percent of the amount of payments under this section that

are attributable to individuals described in subsection (a)(4); and

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

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

(1) IN GENERAL.—The Secretary shall apply such adjustments to the per capita amount computed under subsection (b) as is designed to take into account, in a budget neutral manner and based on the costs estimated under paragraph (2), actuarial differences in health care costs attributable to individuals in different age categories and different geographic locations of primary residences in the State and the reductions based on income under subsection (d). No such adjustment shall be made based on sex.

(2) DATA ON AVERAGE COSTS OF SERVICES.—Not later than December 15 before the beginning of each year, the Agency for Healthcare Research and Quality shall estimate the average cost of health care for such year for individuals under 65 years of age and may estimate how such average varies for

different populations of individuals under age 65. The adjustments under paragraph (1) for age categories for a year shall be based on such estimates made. Not later than such date, the Secretary shall prescribe tables for purposes of making adjustments based on age under paragraph (1) based on such determination which shall apply for taxable years beginning in the succeeding calendar year.

(d) INCOME-RELATED PHASE-OUT.—

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

(2) ZERO PER CAPITA AMOUNT FOR MARRIED FILING SEPARATELY.—The per capita amount under

this section shall be zero in the case of a married couple filing separately.

SEC. 105. STATE OPTIONS FOR IMPROVED ACCESS TO HEALTH INSURANCE COVERAGE IN EACH STATE.

(a) STATE OPTIONS TO IMPROVE ACCESS.—

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

(2) REPURPOSING STATE EXCHANGES.—A State may use or adapt an Exchange that the State has established under title I of PPACA to carry out any such function.

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

(b) TRANSPARENCY PORTAL.—Each State may establish and operate an open and transparent marketplace mechanism whereby qualified residents of the State can readily compare, through the use of the Internet, the bene-

fits and prices between different health insurance coverage options made available to them.

(c) ENROLLMENT, SUBJECT TO INDIVIDUAL OPT-OUT.—A State may provide for the enrollment of qualified residents of the State who are uninsured in default health insurance coverage offered under section 107(c) and establishing a Roth HSA for such residents who do not have a Roth HSA unless the resident has affirmatively elected not to be so enrolled and not to have a Roth HSA, respectively. Any such enrollment under this paragraph shall be coordinated with the annual open enrollment periods provided under section 107(b).

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

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

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

(B) a reinsurance and risk-corridor program that involves no Federal funds with re-

spect to coverage both in the individual market and in the small group market.

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

(e) MODIFIED HEALTH STATUS INSURANCE MECHANISM.—

(1) IN GENERAL.—A State may establish a mechanism for providing modified health status insurance in the State to encourage health plans to implement adequate benefit designs and services for a chronically ill individual.

(2) REQUIREMENTS.—A mechanism under paragraph (1) may implement the following requirements:

(A) During the first open enrollment period after the date of enactment of this Act, an individual health plan shall provide coverage for health benefits as defined in the health plan for a period of 12 months.

(B) If an individual enrolls in a new health plan during the open enrollment period at the end of the first 12 months of coverage under subparagraph (A), the plan in which the individual was enrolled prior to such period shall be responsible for financing 75 percent of the health benefits administered to the individual under any other health plan in which the individual enrolls for the initial 3-month period of coverage under such other plan.

(C) During the 3-month period described in subparagraph (B), the plan in which the individual was enrolled prior to such period shall receive 75 percent of the premiums paid for the individual's coverage under the other health plan.

(D) During the third open enrollment period after the date of enactment of this Act, and during all subsequent open enrollment periods, a health plan that has enrollees terminate their coverage in order to enroll in other health plans shall be responsible for financing 75 percent of the health benefits administered to such enrollees under the other plans and shall receive 75 percent of the premiums paid for such en-

rollees' coverage under such other health plans for the first 3 months of coverage in new plan year.

SEC. 106. STATE FLEXIBILITY IN ENSURING ORDERLY HEALTH INSURANCE MARKET OUTSIDE OF AN EXCHANGE.

(a) IN GENERAL.—With respect to health insurance coverage offered in a State, the State may, in consultation with the Secretary, take such steps, such as limiting the availability of general open enrollment periods, imposing delays in the effectiveness for coverage, permitting differentials in premiums based on age and other factors, as the State determines necessary in order to ensure an orderly market for health insurance coverage in the State that is not offered through an Exchange. Such steps may include the establishment of an initial open enrollment period during which qualified residents may enroll in health insurance coverage without the imposition of any underwriting as the State determines to be appropriate in ensuring initial access to such coverage.

(b) FLEXIBILITY IN IMPOSING ADDITIONAL REQUIREMENTS.—Nothing in this section shall be construed as preventing a State from continuing to apply, to health insurance coverage issued in the State, requirements under the provisions of title XXVII of the Public Health

Service Act (as amended by subtitles A and C of title I of PPACA), that are not continued under section 101(b).

(c) STATE FLEXIBILITY WITH RESPECT TO EXCHANGES.—A State may waive such provisions of part 2 of subtitle D of title I of PPACA, in relation to the establishment of an Exchange in such State, as the State determines appropriate in order for the State to implement and administer a market-based system for the availability of health insurance coverage throughout the State.

SEC. 107. EXPANDED ACCESS AND PATIENT PROTECTIONS.

(a) IN GENERAL.—As a condition for the election of the alternative option under section 103 in a State, the State must meet the requirements of this section.

(b) ANNUAL AND OTHER OPEN ENROLLMENT PERIODS.—

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

consistent with the open enrollment periods established under title I of PPACA, as in effect on the day before the date of the enactment of this Act.

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

(c) OFFERING OF DEFAULT HEALTH INSURANCE COVERAGE.—

(1) ENROLLMENT, SUBJECT TO INDIVIDUAL OPT-OUT.—Subject to paragraph (4), a State may elect to provide for the enrollment of residents of the State who are uninsured in default health insurance coverage (as defined in paragraph (2)) and establishing a Roth HSA for such residents who do not have a Roth HSA unless the resident has affirmatively elected not to be so enrolled and not to have such an account. respectively. If a State makes such

an election, the State shall permit eligible residents to enroll in such coverage on a continuous basis.

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

(A) is a high deductible health plan (within the meaning of section 223(c)(2) of the Internal Revenue Code of 1986) with prescription drug coverage limited to a Tier 1 formulary benefit (as commonly understood) for a limited number of chronic conditions (commonly referred to as tier I pharmacy benefit);

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

(C) has a provider network for covered benefits that is adequate (as determined consistent with the guidelines issued by the Secretary relating to provider access requirements for Medicare Advantage organizations under section 1852(d) of the Social Security Act (42

U.S.C. 1395w–22(d))) to ensure access to health benefits under such plan;

(D) provides for coverage of childhood immunizations without cost sharing requirements to the extent such immunizations have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

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

(3) ROTH HSA.—In this subsection, the term ''Roth HSA'' shall have the meaning given such term by section 530A(c) of the Internal Revenue Code of 1986.

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

(d) CONSEQUENCES RESPECTING CONTINUOUS COVERAGE.—

(1) CONSEQUENCES FOR NOT MAINTAINING CONTINUOUS COVERAGE.—

(A) AVOIDANCE OF CONSEQUENCES BY MAINTAINING CONTINUOUS COVERAGE.—

(i) IN GENERAL.—All qualified residents of a State are eligible during the initial open enrollment period provided under subsection (b)(2) to enroll in qualified health plan coverage and, thereafter, to maintain continuous coverage in order to avoid the adverse consequences described in the succeeding provisions of this paragraph.

(ii) SPECIAL ENROLLMENT PERIODS.—The State may provide for special enrollment periods based on birth, becoming 26 years of age, and independence from family coverage, during which certain individuals will be eligible to enroll in qualified health plan coverage for purposes of this subsection.

(B) UNDERWRITING PERMITTED.—In the case of a qualified resident of the State who fails to maintain continuous creditable coverage

(not including any breaks in coverage of less than 63 days), the State shall—

(i) permit health insurance issuers for the period specified in subparagraph (C) to medically underwrite (through denial of health insurance coverage, application of preexisting condition limitations, differential premiums, or otherwise) the issuance of health insurance coverage, other than with respect to the issuance of default health insurance coverage under subsection (c); and

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

(C) PERIOD FOR APPLICATION OF UNDERWRITING.—For purposes of subparagraph (B)(i), the period specified in this subparagraph

is, with respect to an uninsured individual as of a date, a period (not to exceed 18 months) equivalent to the number of months in the previous 18-month period in which the individual did not have continuous creditable coverage described in subparagraph (B).

(D) MONTHLY LATE ENROLLMENT PENALTY AMOUNT.—

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

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

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

(ii) PAYMENT OF PENALTY AMOUNT TO FEDERAL TREASURY.—The amount of the monthly late enrollment penalty col-

lected under this subparagraph shall be paid to the Treasury of the United States in a form and manner specified by the Secretary of the Treasury.

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

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

(B) DURING THIRD AND SUBSEQUENT OPEN ENROLLMENT PERIODS.—In the case of a qualified resident who maintains continuous

coverage for a period of 18 months or longer (not including any breaks in coverage of less than 63 days) as of the initial date of a third or subsequent annual open enrollment period established by the State under subsection (b)(1), the State shall require health insurance issuers to permit such residents during such an open enrollment period to change the qualified health plan coverage in which the individual is enrolled without medical underwriting.

SEC. 108. APPLICATION OF HEALTH SAVINGS ACCOUNTS IN RELATION TO MEDICAID.

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

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

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

for purposes of determining eligibility for and the amount of medical assistance for long-term care services (described in section 1917(c)(1)(C)(i)).

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

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

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

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to eligibility determinations with respect to medical assistance for periods beginning on or after January 1, 2018.

Subtitle B—Provider Price Transparency

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

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

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

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

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

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

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

"(A) PHYSICIANS' AND OTHER PROFESSIONAL SERVICES.—For physicians' services or services of a health care provider which constitute medical care (as defined under section 213(d) of the Internal Revenue Code of 1986, as in effect before the date of the enactment of this subsection) (and including drugs and biologicals furnished in conjunction with and billed as part of such services), the lesser of—

"(i) the cash price for such services posted pursuant to section 121(b) of the Patient Freedom Act of 2017; or

"(ii) 85 percent of the usual, customary, and reasonable (UCR) charge for such services, as determined under rules

established by the department of insurance for the State in which the services are furnished.

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

''(i) the cash price for such services posted pursuant to section 121(b) of the Patient Freedom Act of 2017; or

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

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

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

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

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

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

''(i) the cash price for such items and services posted pursuant to section 121(b) of the Patient Freedom Act of 2017; or

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

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

group or bundle of such items and services, the maximum charge permitted under paragraph (1) may not exceed the lesser of—

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

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

(b) REFERENCE TO PRICE DISCLOSURE PROVISION.—

(1) IN GENERAL.—Persons providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986, as in effect before the date of the enactment of this Act) are required to post prices under this subsection.

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

(A) to establish a single price for related items and services in a manner similar to the manner in which pricing and payment for such items and services is provided under the Medi-

care program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.); and

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

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

TITLE II—REFORM OF TAX PROVISIONS RELATING TO HEALTH CARE

Subtitle A—Health Savings Accounts

SEC. 201. TRANSITION TO NON-DEDUCTIBLE HSAS.

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

"PART IX—HEALTH SAVINGS ACCOUNTS

"Sec. 530A. Roth HSAs.

"SEC. 530A. ROTH HSAS.

"(a) IN GENERAL.—With the exception of the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable organizations), a Roth HSA shall be exempt from taxation under this sub-

title. No deduction shall be allowed for any contribution to a Roth HSA.

''(b) DOLLAR LIMITATION.—

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

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

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

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

''(3) ADDITIONAL CONTRIBUTIONS FOR INDIVIDUALS 55 OR OLDER.—In the case of an individual who has attained age 55 before the close of the taxable year, the applicable limitation under subpara-

graphs (A) and (B) of paragraph (2) shall be increased by $1,000.

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

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

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

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

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

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

''(B) the limitation under paragraph (1) (after the application of subparagraph (A) and

without regard to any additional contribution amount under paragraph (3))—

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

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

"(6) DENIAL OF DEDUCTION TO DEPENDENTS.—No contribution may be made to a Roth HSA under this section by any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

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

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

''(A) IN GENERAL.—For purposes of computing the limitation under paragraph (1) for any taxable year, an individual who is an eligible individual during the last month of such taxable year shall be treated—

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

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

''(B) FAILURE TO MAINTAIN CREDITABLE COVERAGE.—

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

''(I) the gross income of the individual for the taxable year in which occurs the first month in the testing period for which such individual is not an eligible individual shall be increased by the aggregate amount of

all contributions to the Roth HSA of the individual which could not have been made but for subparagraph (A), and

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

"(ii) EXCEPTION FOR DISABILITY OR DEATH.—Clause (i) shall not apply if the individual ceased to be an eligible individual by reason of the death of the individual or the individual becoming disabled (within the meaning of section 72(m)(7)).

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

"(9) LIMITATION NOT TO APPLY TO CERTAIN CONTRIBUTIONS MADE UNDER PATIENT FREEDOM ACT.—Any contributions made under 103(b) of the Patient Freedom Act of 2017 or as provided in sec-

tion 36C shall not be taken into account for purposes of determining whether the limitation under paragraph (1) has been met.

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

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

''(A) Except in the case of a rollover contribution described in subsection (e)(5) or sections 220(f)(5) or 223(f)(5), no contribution will be accepted—

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

''(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds the sum of—

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

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

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

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

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

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

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

"(A) IN GENERAL.—The term 'qualified medical expenses' means, with respect to an account beneficiary, amounts paid by such beneficiary for medical care (as defined in section 213(d) as in effect on the day before the date of the enactment of the Patient Freedom Act of 2017) for such individual, the spouse of such individual, and any dependent (as defined in

section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

''(B) LIMITATION ON HEALTH INSURANCE PURCHASED FROM ACCOUNT.—Such term shall not include any payment for health benefits coverage that is not creditable coverage (within the meaning of title XXVII of the Public Health Service Act).

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

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

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

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

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

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

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

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

"(B) Section 219(f)(5) (relating to employer payments).

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

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

"(5) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to Roth HSAs, and any amount treated as distributed under such rules shall be

treated as not used to pay qualified medical expenses.

''(d) ELIGIBLE INDIVIDUAL.—For purposes of this section, the term 'eligible individual' means, with respect to any month, any individual who is covered under creditable coverage (within the meaning of title XXVII of the Public Health Service Act) as of the 1st day of such month.

''(e) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a Roth HSA which is used exclusively to pay qualified medical expenses of any account beneficiary shall not be includible in gross income in the manner provided in section 72.

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

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

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

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

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

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

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

''(B) EXCESS CONTRIBUTION.—For purposes of subparagraph (A), the term 'excess contribution' means any contribution (other than a rollover contribution described in paragraph (5) or sections 220(f)(5) or 223(f)(5)) which exceeds the contribution limitation with respect to the individual for the taxable year.

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

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

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

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

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

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

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

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

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

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

''(f) COST-OF-LIVING ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any calendar year beginning after 2017, the $5,000 dollar amount in subsection (b)(2) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

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

''(i) by substituting 'calendar year 2016' for 'calendar year 1992' in subparagraph (B) thereof, and

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

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

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

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

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

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

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

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

''(i) LIMITED CONTRIBUTIONS AFTER 2016.—

''(1) IN GENERAL.—No contribution may be accepted by a health savings account after the date of the enactment of this subsection.

''(2) EXCEPTIONS.—Paragraph (1) shall not apply to a rollover contribution described in subsection (f)(5).''.

(c) CONFORMING AMENDMENTS.—

(1) Section 26(b)(2) of the Internal Revenue Code of 1986 is amended—

(A) in subparagraph (S), by striking ''and 408(d)(9)(D)(i)(II)'' and inserting ''408(d)(9)(D)(i)(II), and 530A(b)(8)(B)(i)(II)'', and

(B) in subparagraph (U), by inserting ''and section 530A(e)(4)'' before the comma at the end.

(2) Section 35(g)(3) of such Code is amended—

(A) by striking ''or from'' and inserting '', from'', and

(B) by inserting ''or from a Roth HSA (as defined in section 530A(c))'' after ''223(d))''.

(3) Section 220(f)(5)(A) of such Code is amended by inserting ''or a Roth HSA (as defined in section 530A(c))'' after ''223(d))''.

(4) Section 223(f)(5)(A) of such Code is amended by inserting ''or a Roth HSA (as defined in section 530A(c))'' after ''paid into a health savings account''.

(5) Section 408(d)(9) of such Code is amended by adding at the end the following new subparagraph:

''(F) APPLICATION TO ROTH HSAS.—Rules similar to the rules of the preceding subparagraphs of this paragraph shall apply with respect to eligible individuals (as defined in section 530A(d)) making contributions to Roth HSAs, except that subparagraph (C) shall be applied by substituting 'section 530A(b)' for 'section 223(b)'.''.

(6) Section 848(e)(1)(B)(v) of such Code is amended by inserting ''or a Roth HSA (as defined in section 530A(c))'' after ''223(d))''.

(7) Section 877A(e)(2) of such Code is amended by inserting ''a Roth HSA (as defined in section 530A(c),'' after ''223),''.

(8) Section 4973 of such Code is amended—

(A) in subsection (a), by striking ''or'' at the end of paragraph (5), by inserting ''or'' at the end of paragraph (6), and by inserting after paragraph (6) the following new paragraph:

''(7) a Roth HSA (within the meaning of section 530A),'', and

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

''(j) EXCESS CONTRIBUTION TO ROTH HSAS.—For purposes of this section, in the case of Roth HSA (within the meaning of section 530A(c)), the term 'excess contributions' means the sum of—

''(1) the aggregate amount contributed for the taxable year to the accounts (other than a rollover contribution described in section 220(f)(5), 223(f)(5), or 530A(e)(5)), and

''(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of—

"(A) the distributions out of the accounts which were included in gross income under section 530A(e)(2), and

"(B) the excess (if any) of—

"(i) the maximum amount allowable as a contribution under section 530A(b) for the taxable year, over

"(ii) the amount contributed to the accounts for the taxable year.

For purposes of this subsection, any contribution which is distributed out of the Roth HSA in a distribution to which section 530A(e)(3) applies shall be treated as an amount not contributed.".

(9) Section 4975(c) of such Code is amended by adding at the end the following new paragraph:

"(7) SPECIAL RULE FOR ROTH HSAS.—An individual for whose benefit a Roth HSA (within the meaning of section 530A(c)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a Roth HSA by reason of the application of section 530A(c)(5) to such account.".

(10) Section 6051(a)(12) of such Code is amended by inserting ''and to any Roth HSA (as defined in section 530A(c))'' after ''223(d))''.

(11) Section 6693(a)(2) of such Code is amended by striking ''and'' at the end of subparagraph (E), by striking the period at the end of subparagraph (F) and inserting '', and'', and by adding at the end the following new subparagraph:

''(G) section 530A(g) (relating to Roth HSAs).''.

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

''PART IX. ROTH HEALTH SAVINGS ACCOUNTS.''.

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

SEC. 202. TREATMENT OF DIRECT PRIMARY CARE.

(a) HSAs.—

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

physicians of physician professional services (and ancillary services).''.

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

(b) NOT TREATED AS HEALTH INSURANCE COVERAGE.—

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

(2) DIRECT PRIMARY CARE DEFINED.—In this subsection, the term ''direct primary care'' means the furnishing (or access to the furnishing) by a physician or group of physicians of physician professional services (and ancillary services) in return for payment of a monthly or other prepaid amount.

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

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

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

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

Subtitle B—Health Care Tax Credits

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

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

''(E) SPECIAL RULE FOR RESIDENTS OF STATES CONTINUING PPACA IMPLEMENTATION.—No credit shall be allowed under this section to any individual who is not a qualified resident (as defined in section 100(15) of the

Patient Freedom Act of 2017) of a State that has elected the option under section 102(a)(1) of such Act in relation to the implementation of title I of the Patient Protection and Affordable Care Act.''.

(b) LIMITATION ON AMOUNT OF CREDIT.—Section 36B(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(4) LIMITATION ON AMOUNT OF CREDIT.—In the case of any taxable year beginning in a calendar year which begins after the date of the enactment of this paragraph, the Secretary shall reduce the amount determined under this subsection (determined before the application of this paragraph) for each qualified resident (as defined in section 100 of the Patient Freedom Act of 2017) of a State that makes an election under section 102(a)(1) of such Act by an amount equal to—

''(A) the amount of the reduction described in section 102(a)(1)(A) of such Act for such year (calculated by only taking into account credit allowed under this section), divided by

''(B) the total number of such qualified residents of such State estimated by the Sec-

retary to claim the credit allowed under subsection (a) for such year.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after January 1, 2018.

SEC. 212. NEW ROTH HSA CREDIT.

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

''SEC. 36C. ROTH HSA CREDIT.

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

''(b) QUALIFYING INDIVIDUAL.—For purposes of this section, the term 'qualifying individual' means, with respect to any month, any individual who for such month is a deposit qualifying resident (as defined in section 103(b)(2) of the Patient Freedom Act of 2017) of a State described in section 102(a)(2) of such Act that elects to have section 103(b) of such Act carried out by way of the credit determined under this section.

"(c) ROTH HSA CREDIT AMOUNT.—For purposes of this section, the term 'Roth HSA credit amount' means, with respect to any taxable year, the sum of the Roth HSA deposit amounts determined under section 104 of the Patient Freedom Act of 2017 with respect to the individual for all months ending during the taxable year.

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

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

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

"(B) ADVANCE PAYMENT SHORTFALL.—If the credit allowed by this section (determined without regard to this subparagraph) with respect to an individual for a taxable year exceeds the advance payments to such individual for such taxable year under subsection (e), the Secretary shall, in lieu of a credit allowed against the tax imposed by this subtitle, make a pay-

ment on behalf of such individual to such individual's health savings account in an amount equal to such excess.

''(2) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the credit shall be allowed under this section only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

''(e) ADVANCE PAYMENT PROGRAM.—

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

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

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

''(2) PROGRAM REQUIREMENTS.—Such program shall be established under rules similar to the rules of section 1412 of the Patient Protection and Affordable Care Act, except that advance determinations and advance payments shall be made on re-

quest of the individual with respect to whom the determination is to be made and taking into account the enrollment process (including any opt-out election under such process) established under section 105(c) of the Patient Freedom Act of 2017.

''(3) TREATMENT AS INCOME.—The amount of any credit allowed under this section shall be included in gross income.''.

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

''Sec. 36C. Roth HSA credit.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after January 1, 2018.