

113TH CONGRESS
1ST SESSION

H. R. 2900

To repeal the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010; to amend the Internal Revenue Code of 1986 to repeal the percentage floor on medical expense deductions, expand the use of tax-preferred health care accounts, and establish a charity care credit; to amend the Social Security Act to create a Medicare Premium Assistance Program, reform EMTALA requirements, and to replace the Medicaid program and the Children's Health Insurance program with a block grant to the States; to amend the Public Health Service Act to provide for cooperative governing of individual and group health insurance coverage offered in interstate commerce; and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 1, 2013

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

A BILL

To repeal the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010; to amend the Internal Revenue Code of 1986 to repeal the percentage floor on medical expense deductions, expand the use of tax-preferred health care accounts, and establish a charity care credit; to amend the Social Security Act to create a Medicare Premium

Assistance Program, reform EMTALA requirements, and to replace the Medicaid program and the Children’s Health Insurance program with a block grant to the States; to amend the Public Health Service Act to provide for cooperative governing of individual and group health insurance coverage offered in interstate commerce; and for other purposes.

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

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS; CON-**
 4 **STRUCTION.**

5 (a) **SHORT TITLE.**—This Act may be cited as the
 6 “Offering Patients True Individualized Options Now Act
 7 of 2013” or the “**OPTION Act of 2013**”.

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

Sec. 1. Short title; table of contents; construction.

TITLE I—REPEAL OF PPACA AND HCERA

Sec. 101. Repeal of PPACA and HCERA.

TITLE II—HEALTH CARE TAX REFORM

Subtitle A—HSA Reform

Sec. 201. Repeal of high deductible health plan requirement.

Sec. 202. Increase in deductible HSA contribution limitations.

Sec. 203. Medicare eligible individuals eligible to contribute to HSA.

Sec. 204. HSA Rollover to Medicare Advantage MSA.

Sec. 205. Repeal of additional tax on distributions not used for qualified medical expenses.

Subtitle B—Other Health Care Tax Reform

Sec. 206. Elimination of 10-percent floor on medical expense deductions.

Sec. 207. Repeal of prescribed drug limitation on certain tax benefits for medical expenses.

Sec. 208. Repeal of 2-percent miscellaneous itemized deduction floor for medical expense deductions.

Sec. 209. Charity care credit.

- Sec. 210. Credit for contributions made for purpose of providing medical care to the indigent.
- Sec. 211. COBRA continuation coverage extended.
- Sec. 212. HSA charitable contributions.

TITLE III—MEDICARE PREMIUM ASSISTANCE PROGRAM

- Sec. 301. Replacement of Medicare part A entitlement with Medicare Reform Premium Assistance Program.
- Sec. 302. Gradual phasing out of CMS and transfer of functions to Department of the Treasury.

TITLE IV—EMTALA REFORMS

- Sec. 401. EMTALA reforms.

TITLE V—COOPERATIVE GOVERNING OF INDIVIDUAL AND GROUP HEALTH INSURANCE COVERAGE

- Sec. 501. Cooperative governing of individual and group health insurance coverage.
- Sec. 502. Continuing State authority.

TITLE VI—STATE HEALTH FLEXIBILITY

- Sec. 601. Short title.
- Sec. 602. Health grants to the States for health care services to indigent individuals.
- Sec. 603. Repeal of Federal requirements of Medicaid and CHIP.
- Sec. 604. Severability.
- Sec. 605. Effective date.

1 (c) CONSTRUCTION.—Nothing in this Act shall be
 2 construed to preclude or prohibit a health care provider
 3 or health insurance issuer from publicly disclosing any
 4 pricing of services provided or covered.

5 **TITLE I—REPEAL OF PPACA AND** 6 **HCERA**

7 **SEC. 101. REPEAL OF PPACA AND HCERA.**

8 The Patient Protection and Affordable Care Act and
 9 the Health Care and Education Reconciliation Act of 2010
 10 are each repealed, effective as of the respective date of
 11 enactment of each such Act, and the provisions of law

1 amended or repealed by such Acts are restored or revived
2 as if such Acts had not been enacted.

3 **TITLE II—HEALTH CARE TAX**
4 **REFORM**
5 **Subtitle A—HSA Reform**

6 **SEC. 201. REPEAL OF HIGH DEDUCTIBLE HEALTH PLAN RE-**
7 **QUIREMENT.**

8 (a) IN GENERAL.—Section 223 of the Internal Rev-
9 enue Code of 1986 is amended by striking subsection (c)
10 and redesignating subsections (d) through (h) as sub-
11 sections (c) through (g), respectively.

12 (b) CONFORMING AMENDMENTS.—

13 (1) Subsection (a) of section 223 of such Code
14 is amended to read as follows:

15 “(a) DEDUCTION ALLOWED.—In the case of an indi-
16 vidual, there shall be allowed as a deduction for a taxable
17 year an amount equal to the aggregate amount paid in
18 cash during such taxable year by or on behalf of such indi-
19 vidual to a health savings account of such individual.”.

20 (2) Subsection (b) of section 223 of such Code
21 is amended by striking paragraph (8).

22 (3) Subparagraph (A) of section 223(c)(1) of
23 the Internal Revenue Code of 1986 (as redesignated
24 by subsection (b)(1)) is amended—

1 (A) by striking “subsection (f)(5)” and in-
2 serting “subsection (e)(5)”, and

3 (B) in clause (ii)—

4 (i) by striking “the sum of—” and all
5 that follows and inserting “the dollar
6 amount in effect under subsection (b)(1).”.

7 (4) Section 223(f)(1) of such Code (as redesign-
8 nated by subsection (b)(1)) is amended by striking
9 “Each dollar amount in subsections (b)(2) and
10 (c)(2)(A)” and inserting “In the case of a taxable
11 year beginning after December 31, 2010, each dollar
12 amount in subsection (b)(1)”.

13 (5) Section 26(b)(U) of such Code is amended
14 by striking “section 223(f)(4)” and inserting “sec-
15 tion 223(e)(4)”.

16 (6) Sections 35(g)(3), 220(f)(5)(A),
17 848(e)(1)(v), 4973(a)(5), and 6051(a)(12) of such
18 Code are each amended by striking “section 223(d)”
19 each place it appears and inserting “section 223(c)”.

20 (7) Section 106(d)(1) of such Code is amend-
21 ed—

22 (A) by striking “who is an eligible indi-
23 vidual (as defined in section 223(c)(1))”, and

24 (B) by striking “section 223(d)” and in-
25 serting “section 223(c)”.

1 (8) Section 408(d)(9) of such Code is amend-
2 ed—

3 (A) in subparagraph (A) by striking “who
4 is an eligible individual (as defined in section
5 223(c)) and”, and

6 (B) in subparagraph (C) by striking “com-
7 puted on the basis of the type of coverage under
8 the high deductible health plan covering the in-
9 dividual at the time of the qualified HSA fund-
10 ing distribution”.

11 (9) Section 877A(g)(6) of such Code is amend-
12 ed by striking “223(f)(4)” and inserting
13 “223(e)(4)”.

14 (10) Section 4973(g) of such Code is amend-
15 ed—

16 (A) by striking “section 223(d)” and in-
17 serting “section 223(c)”,

18 (B) in paragraph (2), by striking “section
19 223(f)(2)” and inserting “section 223(e)(2)”,
20 and

21 (C) by striking “section 223(f)(3)” and in-
22 serting “section 223(e)(3)”.

23 (11) Section 4975 of such Code is amended—

24 (A) in subsection (c)(6)—

1 (i) by striking “section 223(d)” and
2 inserting “section 223(c)”, and

3 (ii) by striking “section 223(e)(2)”
4 and inserting “section 223(d)(2)”, and

5 (B) in subsection (e)(1)(E), by striking
6 “section 223(d)” and inserting “section
7 223(c)”.

8 (12) Section 6693(a)(2)(C) of such Code is
9 amended by striking “section 223(h)” and inserting
10 “section 223(g)”.

11 (c) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to taxable years beginning after
13 December 31, 2012.

14 **SEC. 202. INCREASE IN DEDUCTIBLE HSA CONTRIBUTION**
15 **LIMITATIONS.**

16 (a) IN GENERAL.—Paragraph (1) of section 223(b)
17 of the Internal Revenue Code of 1986 is amended by strik-
18 ing “the sum of the monthly” and all that follows through
19 “eligible individual” and inserting “\$10,000 (\$20,000 in
20 the case of a joint return)”.

21 (b) CONFORMING AMENDMENTS.—

22 (1) Subsection (b) of such Code is amended by
23 striking paragraphs (2), (3), and (5) and by redesignig-
24 nating paragraphs (4), (6), and (7) as paragraphs
25 (2), (3), and (4), respectively.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 2012.

4 **SEC. 204. HSA ROLLOVER TO MEDICARE ADVANTAGE MSA.**

5 (a) IN GENERAL.—Paragraph (2) of section 138(b)
6 of the Internal Revenue Code of 1986 is amended by strik-
7 ing “or” at the end of subparagraph (A), by adding “or”
8 at the end of subparagraph (C), and by adding at the end
9 the following new subparagraph:

10 “(C) a HSA rollover contribution described
11 in subsection (d)(5),”.

12 (b) HSA ROLLOVER CONTRIBUTION.—Subsection (c)
13 of section 138 of such Code is amended by adding at the
14 end the following new paragraph:

15 “(5) ROLLOVER CONTRIBUTION.—An amount is
16 described in this paragraph as a rollover contribu-
17 tion if it meets the requirement of subparagraphs
18 (A) and (B).

19 “(A) IN GENERAL.—The requirements of
20 this subparagraph are met in the case of an
21 amount paid or distributed from a health sav-
22 ings to the account beneficiary to the extent the
23 amount is received is paid into a Medicare Ad-
24 vantage MSA of such beneficiary not later than

1 the 60th day after the day on which the bene-
2 ficiary receives the payment or distribution.

3 “(B) LIMITATION.—This paragraph shall
4 not apply to any amount described in subpara-
5 graph (A) received by an individual from a
6 health savings account if, at any time during
7 the 1-year period ending on the day of such re-
8 ceipt, such individual received any other amount
9 described in subparagraph (A) from a health
10 savings account which was not includible in the
11 individual’s gross income because of the appli-
12 cation of section 223(f)(5)(A).”.

13 (c) CONFORMING AMENDMENT.—Subparagraph (A)
14 of section 223(f)(5) of such Code is amended by inserting
15 “or Medicare Advantage MSA” after “into a health sav-
16 ings account”.

17 (d) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to taxable years beginning after
19 December 31, 2012.

20 **SEC. 205. REPEAL OF ADDITIONAL TAX ON DISTRIBUTIONS**

21 **NOT USED FOR QUALIFIED MEDICAL EX-**
22 **PENSES.**

23 (a) IN GENERAL.—Subsection (f) of section 223 of
24 the Internal Revenue Code of 1986 is amended by striking

1 paragraph (4) and redesignating paragraphs (5), (6), and
2 (7) and paragraphs (4), (5), and (6), respectively.

3 (b) CONFORMING AMENDMENTS.—

4 (1) Paragraph (2) of section 25(b) of such Code
5 is amended by striking subparagraph (U) and by re-
6 designating subparagraphs (V), (W), and (X) as
7 subparagraphs (U), (V), and (W).

8 (2) Subparagraph (C) of section 106(e)(4) of
9 such Code is amended by striking “223(f)(5)” and
10 inserting “223(f)(4)”.

11 (3) Paragraph (6) of section 877A(g) of such
12 Code is amended by striking “223(f)(4),”.

13 (4) Paragraph (1) of section 4973(g) of such
14 Code is amended by striking “223(f)(5)” and insert-
15 ing “223(f)(4)”.

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to taxable years beginning after
18 December 31, 2012.

19 **Subtitle B—Other Health Care Tax** 20 **Reform**

21 **SEC. 206. ELIMINATION OF 10-PERCENT FLOOR ON MED-** 22 **ICAL EXPENSE DEDUCTIONS.**

23 (a) IN GENERAL.—Subsection (a) of section 213 of
24 the Internal Revenue Code of 1986 is amended by striking

1 “, to the extent that such expenses exceed 10 percent of
2 adjusted gross income”.

3 (b) CONFORMING AMENDMENT.—Paragraph (1) of
4 section 56(b) of such Code is amended by striking sub-
5 paragraph (B).

6 (c) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to taxable years beginning after
8 December 31, 2012.

9 **SEC. 207. REPEAL OF PRESCRIBED DRUG LIMITATION ON**
10 **CERTAIN TAX BENEFITS FOR MEDICAL EX-**
11 **PENSES.**

12 (a) DEDUCTION FOR MEDICAL EXPENSES.—

13 (1) IN GENERAL.—Section 213 of the Internal
14 Revenue Code of 1986 is amended by striking sub-
15 section (b).

16 (2) CONFORMING AMENDMENT.—Subsection (d)
17 of section 213 of such Code is amended by striking
18 paragraph (3).

19 (b) TREATMENT OF REIMBURSEMENTS UNDER ACCI-
20 DENT OR HEALTH PLANS.—Section 106 of such Code is
21 amended by striking subsection (f).

22 (c) HEALTH SAVINGS ACCOUNTS.—Subparagraph
23 (A) of section 223(d)(2) of such Code is amended by strik-
24 ing the last sentence thereof.

1 (d) ARCHER MSAS.—Subparagraph (A) of section
2 220(d)(2) of such Code is amended by striking the last
3 sentence thereof.

4 (e) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to taxable years beginning after
6 December 31, 2012.

7 **SEC. 208. REPEAL OF 2-PERCENT MISCELLANEOUS**
8 **ITEMIZED DEDUCTION FLOOR FOR MEDICAL**
9 **EXPENSE DEDUCTIONS.**

10 (a) IN GENERAL.—Subsection (b) of section 67 of the
11 Internal Revenue Code of 1986 is amended by striking
12 paragraph (5).

13 (b) EFFECTIVE DATE.—The amendment made by
14 this section shall apply to taxable years beginning after
15 the December 31, 2012.

16 **SEC. 209. CHARITY CARE CREDIT.**

17 (a) IN GENERAL.—Subpart A of part IV of sub-
18 chapter A of chapter 1 of the Internal Revenue Code of
19 1986 (relating to nonrefundable personal credits) is
20 amended by inserting after section 25D the following new
21 section:

22 **“SEC. 25E. CHARITY CARE CREDIT.**

23 **“(a) ALLOWANCE OF CREDIT.—**In the case of a phy-
24 **sician, there shall be allowed as a credit against the tax**

1 imposed by this chapter for a taxable year the amount
 2 determined in accordance with the following table:

“If the physician has provided during such taxable year:	The amount of the credit is:
At least 25 but less than 30 qualified hours of charity care	\$2,000.
At least 30 but less than 35 qualified hours of charity care	\$2,400.
At least 35 but less than 40 qualified hours of charity care	\$2,800.
At least 40 but less than 45 qualified hours of charity care	\$3,200.
At least 45 but less than 50 qualified hours of charity care	\$3,600.
At least 50 but less than 55 qualified hours of charity care	\$4,000.
At least 55 but less than 60 qualified hours of charity care	\$4,400.
At least 60 but less than 65 qualified hours of charity care	\$4,800.
At least 65 but less than 70 qualified hours of charity care	\$5,200.
At least 70 but less than 75 qualified hours of charity care	\$5,600.
At least 75 but less than 80 qualified hours of charity care	\$6,000.
At least 80 but less than 85 qualified hours of charity care	\$6,400.
At least 85 but less than 90 qualified hours of charity care	\$6,800.
At least 90 but less than 95 qualified hours of charity care	\$7,200.
At least 95 but less than 100 qualified hours of charity care	\$7,600.
At least 100 hours of charity care	\$8,000.

3 “(b) QUALIFIED HOURS OF CHARITY CARE.—For
 4 purposes of this section—

5 “(1) QUALIFIED HOURS OF CHARITY CARE.—

6 The term ‘qualified hours of charity care’ means the
 7 hours that a physician provides medical care (as de-
 8 fined in section 213(d)(1)(A)) on a volunteer or pro
 9 bono basis.

1 “(2) PHYSICIAN.—The term ‘physician’ has the
2 meaning given to such term in section 1861(r) of the
3 Social Security Act (42 U.S.C. 1395x(r)).”.

4 (b) CONFORMING AMENDMENT.—The table of sec-
5 tions for subpart A of part IV of subchapter A of chapter
6 1 of such Code is amended by inserting after the item
7 relating to section 25D the following new item:

 “Sec. 25E. Charity care credit.”.

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to taxable years beginning after
10 December 31, 2012.

11 **SEC. 210. CREDIT FOR CONTRIBUTIONS MADE FOR PUR-**
12 **POSE OF PROVIDING MEDICAL CARE TO THE**
13 **INDIGENT.**

14 (a) IN GENERAL.—Subpart B of part IV of sub-
15 chapter A of chapter 1 of the Internal Revenue Code of
16 1986 is amended by adding at the end the following new
17 section:

18 **“SEC. 30E. CONTRIBUTIONS FOR PROVIDING MEDICAL**
19 **CARE TO THE INDIGENT.**

20 “(a) IN GENERAL.—There shall be allowed as a cred-
21 it against the tax imposed by this chapter for the taxable
22 year an amount equal to the indigent care contributions
23 made by the taxpayer during the taxable year.

24 “(b) INDIGENT CARE CONTRIBUTION.—For purposes
25 of this section, the term ‘indigent care contribution’ means

1 any contribution or gift of money or other property to or
2 for the use of any person if such contribution or gift is
3 used (or the proceeds from which are used) by such person
4 for the purpose of providing medical care to indigent indi-
5 viduals in the United States.

6 “(c) VALUATION AND SUBSTANTIATION OF CON-
7 TRIBUTIONS, ETC.—Rules similar to the rules of sub-
8 sections (e) and (f) of section 170 shall apply for purposes
9 of this section.

10 “(d) APPLICATION WITH OTHER CREDITS.—

11 “(1) BUSINESS CREDIT TREATED AS PART OF
12 GENERAL BUSINESS CREDIT.—So much of the credit
13 which would be allowed under subsection (a) for any
14 taxable year (determined without regard to this sub-
15 section) that is attributable to indigent care con-
16 tributions made by—

17 “(A) any corporation or partnership, or

18 “(B) any other person if such contribution
19 was made in connection with a trade or busi-
20 ness carried on by such person,
21 shall be treated as a credit listed in section 38(b) for
22 such taxable year (and not allowed under subsection
23 (a)).

24 “(2) PERSONAL CREDIT.—For purposes of this
25 title, the credit allowed under subsection (a) for any

1 taxable year (determined after application of para-
2 graph (1)) shall be treated as a credit allowable
3 under subpart A for such taxable year.

4 “(e) DENIAL OF DOUBLE BENEFIT.—The amount of
5 any deduction or other credit allowable under this chapter
6 for any indigent care contribution shall be reduced by the
7 amount of credit allowable under this section for such con-
8 tribution.”.

9 (b) CONFORMING AMENDMENTS.—

10 (1) Section 38(b) of such Code is amended by
11 striking “plus” at the end of paragraph (35), by
12 striking the period at the end of paragraph (36) and
13 inserting “, plus”, and by adding at the end the fol-
14 lowing new paragraph:

15 “(37) the portion of the credit described in sec-
16 tion 30E(d)(1) (relating to credit for contributions
17 for providing medical care to the indigent).”.

18 (2) Section 38(c)(4)(B) of such Code is amend-
19 ed by striking “and” at the end of clause (viii), by
20 striking the period at the end of clause (ix) and in-
21 sserting “, and”, and by adding at the end the fol-
22 lowing new clause:

23 “(x) the portion of the credit de-
24 scribed in section 30E(d)(1) (relating to

1 credit for contributions for providing med-
2 ical care to the indigent).”.

3 (3) The table of sections for subpart B of part
4 IV of subchapter A of chapter 1 of such Code is
5 amended by adding at the end the following new
6 item:

“Sec. 30E. Contributions for providing medical care to the indigent.”.

7 (c) EFFECTIVE DATE.—The amendments made by
8 this section shall apply to contributions made after the
9 date of the enactment of this Act.

10 **SEC. 211. COBRA CONTINUATION COVERAGE EXTENDED.**

11 (a) UNDER IRC.—Subparagraph (B) of section
12 4980B(f)(2) of the Internal Revenue Code of 1986 is
13 amended by striking clauses (i) and (v) and by redesignig-
14 nating clauses (ii), (iii), and (iv) as clauses (i), (ii), and
15 (iii), respectively.

16 (b) UNDER ERISA.—Paragraph (2) of section 602
17 of the Employee Retirement Income Security Act of 2009
18 (29 U.S.C. 1162) is amended by striking subparagraphs
19 (A) and (E) and by redesignating subparagraphs (B), (C),
20 and (D) as subparagraphs (A), (B), and (C), respectively.

21 (c) UNDER PHSA.—Paragraph (2) of section
22 2202(2) of the Public Health Service Act (42 U.S.C.
23 300bb–2(2)) is amended by striking subparagraphs (A)
24 and (E) and by redesignating subparagraphs (B), (C), and
25 (D) as subparagraphs (A), (B), and (C), respectively.

1 (d) EFFECTIVE DATE.—The amendments made by
2 this section shall apply with respect to group health plans,
3 and health insurance coverage offered in connection with
4 group health plans, for plan years beginning after the date
5 of the enactment of this Act.

6 **SEC. 212. HSA CHARITABLE CONTRIBUTIONS.**

7 (a) IN GENERAL.—Subsection (f) of section 223 of
8 the Internal Revenue Code of 1986 is amended by adding
9 at the end the following new paragraph:

10 “(9) DISTRIBUTIONS FOR CHARITABLE PUR-
11 POSES.—For purposes of this subsection—

12 “(A) IN GENERAL.—Paragraph (2) shall
13 not apply to any qualified charitable distribu-
14 tions with respect to a taxpayer made during
15 any taxable year.

16 “(B) QUALIFIED CHARITABLE DISTRIBUTION.—For purposes of this paragraph, the
17 term ‘qualified charitable distribution’ means
18 any distribution from a health savings account
19 which is made directly by the trustee to an or-
20 ganization described in section 170(b)(1)(A)
21 (other than any organization described in sec-
22 tion 509(a)(3) or any fund or account described
23 in section 4966(d)(2)). A distribution shall be
24 treated as a qualified charitable distribution
25

1 only to the extent that the distribution would be
2 includible in gross income without regard to
3 subparagraph (A).

4 “(C) CONTRIBUTIONS MUST BE OTHER-
5 WISE DEDUCTIBLE.—For purposes of this para-
6 graph, a distribution to an organization de-
7 scribed in subparagraph (B) shall be treated as
8 a qualified charitable distribution only if a de-
9 duction for the entire distribution would be al-
10 lowable under section 170 (determined without
11 regard to subsection (b) thereof and this para-
12 graph).

13 “(D) DENIAL OF DEDUCTION.—Qualified
14 charitable distributions which are not includible
15 in gross income pursuant to subparagraph (A)
16 shall not be taken into account in determining
17 the deduction under section 170.”.

18 (b) EFFECTIVE DATE.—The amendment made by
19 this section shall apply to taxable years beginning after
20 December 31, 2012.

1 **TITLE III—MEDICARE PREMIUM**
2 **ASSISTANCE PROGRAM**

3 **SEC. 301. REPLACEMENT OF MEDICARE PART A ENTITLE-**
4 **MENT WITH MEDICARE REFORM PREMIUM**
5 **ASSISTANCE PROGRAM.**

6 (a) IN GENERAL.—Section 226 of the Social Security
7 Act (42 U.S.C. 426) is amended by adding at the end the
8 following new subsections:

9 “(k) REPLACEMENT OF ENTITLEMENT WITH PRE-
10 MIUM ASSISTANCE PROGRAM.—

11 “(1) IN GENERAL.—Notwithstanding the pre-
12 vious provisions of this section, beginning the first
13 January 1 after the date of the enactment of the Of-
14 fering Patients True Individualized Options Now Act
15 of 2013, the Secretary shall establish procedures
16 under which—

17 “(A) in the case of an individual who, but
18 for the application of this paragraph, would
19 otherwise become entitled under subsection (a)
20 on or after such January 1 to benefits under
21 part A of title XVIII, subject to paragraph (4),
22 the individual shall in lieu of such entitlement
23 be automatically enrolled in the Medicare Re-
24 form Premium Assistance Program established
25 under subsection (l); and

1 “(B) in the case of an individual who be-
2 fore such January 1 is entitled under sub-
3 section (a) to benefits under part A of title
4 XVIII, the individual may in lieu of such enti-
5 tlement elect on or after such January 1 to en-
6 roll in the Medicare Reform Premium Assist-
7 ance Program established under subsection (l).

8 “(2) TREATMENT UNDER THE INTERNAL REV-
9 ENUE CODE OF 1986.—An individual who is enrolled
10 under the Medicare Reform Premium Assistance
11 Program under paragraph (1) shall not be treated
12 as entitled to benefits under title XVIII for purposes
13 of section 223(b)(7) of the Internal Revenue Code of
14 1986.

15 “(3) INELIGIBILITY FOR PART B OR D BENE-
16 FITS.—An individual shall not be eligible for benefits
17 under part B or D of title XVIII once the individual
18 is enrolled in the Medicare Reform Premium Assist-
19 ance Program under paragraph (1).

20 “(4) OPT OUT.—

21 “(A) IN GENERAL.—Any individual who is
22 otherwise eligible for automatic enrollment in
23 the Medicare Reform Premium Assistance Pro-
24 gram under paragraph (1)(A) may elect (in
25 such form and manner as may be specified by

1 the Secretary of Health and Human Services)
2 to not be so enrolled.

3 “(B) INDIVIDUALS ELECTING TO OPT OUT
4 NOT TREATED AS ENTITLED TO MEDICARE
5 BENEFITS.—In the case of an individual who
6 makes an election under subparagraph (A)—

7 “(i) such individual shall not be eligi-
8 ble for benefits under part A of title
9 XVIII; and

10 “(ii) the provisions of paragraphs (2)
11 and (3) shall apply to such individual in
12 the same manner as such paragraphs apply
13 to an individual enrolled under the Medi-
14 care Reform Premium Assistance Program
15 under paragraph (1).

16 “(1) MEDICARE REFORM PREMIUM ASSISTANCE.—

17 “(1) ESTABLISHMENT OF PREMIUM ASSIST-
18 ANCE PROGRAM.—The Secretary shall establish a
19 program to be known as the Medicare Reform Pre-
20 mium Assistance Program (in this subsection re-
21 ferred to as the ‘premium assistance program’) con-
22 sistent with this subsection.

23 “(2) AUTOMATIC ENROLLMENT.—An individual
24 otherwise entitled under subsection (a) to benefits
25 under part A of title XVIII shall, subject to sub-

1 section (k)(4), be enrolled in the premium assistance
2 program for the period during which such individual
3 would otherwise be so entitled to benefits.

4 “(3) AMOUNT OF PREMIUM ASSISTANCE.—

5 “(A) IN GENERAL.—Subject to clause (ii),
6 for each year that an individual is enrolled in
7 the premium assistance program, the Secretary
8 shall provide premium assistance to such indi-
9 vidual in an amount determined by the Sec-
10 retary that is based on the geographic location
11 of the individual and the cost of applicable
12 health insurance coverage and benefits in such
13 area.

14 “(B) COMPUTATION OF PREMIUM ASSIST-
15 ANCE AMOUNTS.—The amount of premium as-
16 sistance provided to an individual located in a
17 geographic area for a year shall be computed at
18 100 percent of the sum of the median premium
19 and median deductible payment for such year
20 for all health insurance coverage offered by
21 health insurance issuers in the individual mar-
22 ket serving such area.

23 “(4) PERMISSIBLE USE OF PREMIUM ASSIST-
24 ANCE.—Premium assistance under paragraph (3)
25 may be used only for the following purposes:

1 duties and responsibilities of such Administrator and Cen-
 2 ters to such an office and official within the Department
 3 of the Treasury as the Secretary of the Treasury shall
 4 specify.

5 (b) REFERENCES.—Any reference in law to the Ad-
 6 ministrator of the Centers for Medicare & Medicaid Serv-
 7 ices, or to such Centers, is deemed to include a reference
 8 to such official and office, respectively, within the Depart-
 9 ment of the Treasury as is specified under subsection (a).

10 **TITLE IV—EMTALA REFORMS**

11 **SEC. 401. EMTALA REFORMS.**

12 (a) USE OF QUALIFIED EMERGENCY DEPARTMENT
 13 PERSONNEL IN PERFORMING INITIAL SCREENING.—Sub-
 14 section (a) of section 1867 of the Social Security Act (42
 15 U.S.C. 1395dd) is amended—

16 (1) by designating the sentence beginning with
 17 “In the case of” as paragraph (1), with the heading
 18 “IN GENERAL.—” and appropriate indentation; and

19 (2) by adding at the end the following new
 20 paragraph:

21 “(2) PERMITTING APPLICATION OF ER
 22 TRIAGE.—

23 “(A) IN GENERAL.—The requirement of
 24 paragraph (1) that a hospital conduct an appro-
 25 priate medical screening examination of an indi-

1 vidual is deemed to be satisfied if a qualified
2 emergency screener (as defined in subparagraph
3 (B)) performs a preliminary triage-type screen-
4 ing in which the personnel—

5 “(i) assesses the nature and extent of
6 the individual’s illness or injury; and

7 “(ii) determines, based on such as-
8 sessment, that an emergency medical con-
9 dition does not exist.

10 “(B) QUALIFIED EMERGENCY SCREENER
11 DEFINED.—In this paragraph, the term ‘quali-
12 fied emergency screener’ means a physician, li-
13 censed practical nurse or registered nurse,
14 qualified emergency medical technician, or other
15 individual with basic, health care education that
16 meets standards specified by the Secretary as
17 being sufficient to perform the screening de-
18 scribed in subparagraph (A).”.

19 (b) REVISION OF EMERGENCY MEDICAL CONDITION
20 DEFINITION.—Subsection (e)(1)(A) of such section is
21 amended to read as follows:

22 “(A) a medical condition manifesting itself
23 by symptoms of sufficient severity (including se-
24 vere pain) and with an onset or of a course
25 such that the absence of immediate medical at-

1 tention could reasonably be expected to pose an
 2 immediate risk to life or long-term health of the
 3 individual (or, with respect to a pregnant
 4 woman, the life or long-term health of the
 5 woman or her unborn child); or”.

6 (c) EFFECTIVE DATE.—The amendments made by
 7 this section shall take effect on the date of the enactment
 8 of this Act and shall apply to individuals who come to an
 9 emergency room on or after the date that is 30 days after
 10 the date of the enactment of this Act.

11 **TITLE V—COOPERATIVE GOV-**
 12 **ERNING OF INDIVIDUAL AND**
 13 **GROUP HEALTH INSURANCE**
 14 **COVERAGE**

15 **SEC. 501. COOPERATIVE GOVERNING OF INDIVIDUAL AND**
 16 **GROUP HEALTH INSURANCE COVERAGE.**

17 (a) IN GENERAL.—Title XXVII of the Public Health
 18 Service Act (42 U.S.C. 300gg et seq.) is amended by add-
 19 ing at the end the following new part:

20 **“PART D—COOPERATIVE GOVERNING OF INDI-**
 21 **VIDUAL AND GROUP HEALTH INSURANCE**
 22 **COVERAGE**

23 **“SEC. 2795. DEFINITIONS.**

24 “In this part:

1 “(1) PRIMARY STATE.—The term ‘primary
2 State’ means, with respect to individual or group
3 health insurance coverage offered by a health insur-
4 ance issuer, the State designated by the issuer as
5 the State whose covered laws shall govern the health
6 insurance issuer in the sale of such coverage under
7 this part. An issuer, with respect to a particular pol-
8 icy, may only designate one such State as its pri-
9 mary State with respect to all such coverage it of-
10 fers. Such an issuer may not change the designated
11 primary State with respect to individual or group
12 health insurance coverage once the policy is issued,
13 except that such a change may be made upon re-
14 newal of the policy. With respect to such designated
15 State, the issuer is deemed to be doing business in
16 that State.

17 “(2) SECONDARY STATE.—The term ‘secondary
18 State’ means, with respect to individual or group
19 health insurance coverage offered by a health insur-
20 ance issuer, any State that is not the primary State.
21 In the case of a health insurance issuer that is sell-
22 ing a policy in, or to a resident of, a secondary
23 State, the issuer is deemed to be doing business in
24 that secondary State.

1 “(3) HEALTH INSURANCE ISSUER.—The term
2 ‘health insurance issuer’ has the meaning given such
3 term in section 2791(b)(2), except that such an
4 issuer must be licensed in the primary State and be
5 qualified to sell individual health insurance coverage
6 in that State.

7 “(4) INDIVIDUAL HEALTH INSURANCE COV-
8 ERAGE.—The term ‘individual health insurance cov-
9 erage’ means health insurance coverage offered in
10 the individual market, as defined in section
11 2791(e)(1).

12 “(5) GROUP HEALTH INSURANCE COVERAGE.—
13 The term ‘group health insurance coverage’ has the
14 meaning given such term in 2791(b)(4).

15 “(6) APPLICABLE STATE AUTHORITY.—The
16 term ‘applicable State authority’ means, with respect
17 to a health insurance issuer in a State, the State in-
18 surance commissioner or official or officials des-
19 ignated by the State to enforce the requirements of
20 this title for the State with respect to the issuer.

21 “(7) HAZARDOUS FINANCIAL CONDITION.—The
22 term ‘hazardous financial condition’ means that,
23 based on its present or reasonably anticipated finan-
24 cial condition, a health insurance issuer is unlikely
25 to be able—

1 “(A) to meet obligations to policyholders
2 with respect to known claims and reasonably
3 anticipated claims; or

4 “(B) to pay other obligations in the normal
5 course of business.

6 “(8) COVERED LAWS.—

7 “(A) IN GENERAL.—The term ‘covered
8 laws’ means the laws, rules, regulations, agree-
9 ments, and orders governing the insurance busi-
10 ness pertaining to—

11 “(i) individual or group health insur-
12 ance coverage issued by a health insurance
13 issuer;

14 “(ii) the offer, sale, rating (including
15 medical underwriting), renewal, and
16 issuance of individual or group health in-
17 surance coverage to an individual;

18 “(iii) the provision to an individual in
19 relation to individual or group health in-
20 surance coverage of health care and insur-
21 ance related services;

22 “(iv) the provision to an individual in
23 relation to individual or group health in-
24 surance coverage of management, oper-

1 ations, and investment activities of a
2 health insurance issuer; and

3 “(v) the provision to an individual in
4 relation to individual or group health in-
5 surance coverage of loss control and claims
6 administration for a health insurance
7 issuer with respect to liability for which
8 the issuer provides insurance.

9 “(B) EXCEPTION.—Such term does not in-
10 clude any law, rule, regulation, agreement, or
11 order governing the use of care or cost manage-
12 ment techniques, including any requirement re-
13 lated to provider contracting, network access or
14 adequacy, health care data collection, or quality
15 assurance.

16 “(9) STATE.—The term ‘State’ means the 50
17 States and includes the District of Columbia, Puerto
18 Rico, the Virgin Islands, Guam, American Samoa,
19 and the Northern Mariana Islands.

20 “(10) UNFAIR CLAIMS SETTLEMENT PRAC-
21 TICES.—The term ‘unfair claims settlement prac-
22 tices’ means only the following practices:

23 “(A) Knowingly misrepresenting to claim-
24 ants and insured individuals relevant facts or
25 policy provisions relating to coverage at issue.

1 “(B) Failing to acknowledge with reason-
2 able promptness pertinent communications with
3 respect to claims arising under policies.

4 “(C) Failing to adopt and implement rea-
5 sonable standards for the prompt investigation
6 and settlement of claims arising under policies.

7 “(D) Failing to effectuate prompt, fair,
8 and equitable settlement of claims submitted in
9 which liability has become reasonably clear.

10 “(E) Refusing to pay claims without con-
11 ducting a reasonable investigation.

12 “(F) Failing to affirm or deny coverage of
13 claims within a reasonable period of time after
14 having completed an investigation related to
15 those claims.

16 “(G) A pattern or practice of compelling
17 insured individuals or their beneficiaries to in-
18 stitute suits to recover amounts due under its
19 policies by offering substantially less than the
20 amounts ultimately recovered in suits brought
21 by them.

22 “(H) A pattern or practice of attempting
23 to settle or settling claims for less than the
24 amount that a reasonable person would believe
25 the insured individual or his or her beneficiary

1 was entitled by reference to written or printed
2 advertising material accompanying or made
3 part of an application.

4 “(I) Attempting to settle or settling claims
5 on the basis of an application that was materi-
6 ally altered without notice to, or knowledge or
7 consent of, the insured.

8 “(J) Failing to provide forms necessary to
9 present claims within 15 calendar days of a re-
10 quests with reasonable explanations regarding
11 their use.

12 “(K) Attempting to cancel a policy in less
13 time than that prescribed in the policy or by the
14 law of the primary State.

15 “(11) FRAUD AND ABUSE.—The term ‘fraud
16 and abuse’ means an act or omission committed by
17 a person who, knowingly and with intent to defraud,
18 commits, or conceals any material information con-
19 cerning, one or more of the following:

20 “(A) Presenting, causing to be presented
21 or preparing with knowledge or belief that it
22 will be presented to or by an insurer, a rein-
23 surer, broker or its agent, false information as
24 part of, in support of or concerning a fact ma-
25 terial to one or more of the following:

1 “(i) An application for the issuance or
2 renewal of an insurance policy or reinsur-
3 ance contract.

4 “(ii) The rating of an insurance policy
5 or reinsurance contract.

6 “(iii) A claim for payment or benefit
7 pursuant to an insurance policy or reinsur-
8 ance contract.

9 “(iv) Premiums paid on an insurance
10 policy or reinsurance contract.

11 “(v) Payments made in accordance
12 with the terms of an insurance policy or
13 reinsurance contract.

14 “(vi) A document filed with the com-
15 missioner or the chief insurance regulatory
16 official of another jurisdiction.

17 “(vii) The financial condition of an in-
18 surer or reinsurer.

19 “(viii) The formation, acquisition,
20 merger, reconsolidation, dissolution or
21 withdrawal from one or more lines of in-
22 surance or reinsurance in all or part of a
23 State by an insurer or reinsurer.

24 “(ix) The issuance of written evidence
25 of insurance.

1 “(x) The reinstatement of an insur-
2 ance policy.

3 “(B) Solicitation or acceptance of new or
4 renewal insurance risks on behalf of an insurer
5 reinsurer or other person engaged in the busi-
6 ness of insurance by a person who knows or
7 should know that the insurer or other person
8 responsible for the risk is insolvent at the time
9 of the transaction.

10 “(C) Transaction of the business of insur-
11 ance in violation of laws requiring a license, cer-
12 tificate of authority or other legal authority for
13 the transaction of the business of insurance.

14 “(D) Attempt to commit, aiding or abet-
15 ting in the commission of, or conspiracy to com-
16 mit the acts or omissions specified in this para-
17 graph.

18 **“SEC. 2796. APPLICATION OF LAW.**

19 “(a) IN GENERAL.—The covered laws of the primary
20 State shall apply to individual and group health insurance
21 coverage offered by a health insurance issuer in the pri-
22 mary State and in any secondary State, but only if the
23 coverage and issuer comply with the conditions of this sec-
24 tion with respect to the offering of coverage in any sec-
25 ondary State.

1 “(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-
2 ONDARY STATE.—Except as provided in this section, a
3 health insurance issuer with respect to its offer, sale, rat-
4 ing (including medical underwriting), renewal, and
5 issuance of individual or group health insurance coverage
6 in any secondary State is exempt from any covered laws
7 of the secondary State (and any rules, regulations, agree-
8 ments, or orders sought or issued by such State under or
9 related to such covered laws) to the extent that such laws
10 would—

11 “(1) make unlawful, or regulate, directly or in-
12 directly, the operation of the health insurance issuer
13 operating in the secondary State, except that any
14 secondary State may require such an issuer—

15 “(A) to pay, on a nondiscriminatory basis,
16 applicable premium and other taxes (including
17 high risk pool assessments) which are levied on
18 insurers and surplus lines insurers, brokers, or
19 policyholders under the laws of the State;

20 “(B) to register with and designate the
21 State insurance commissioner as its agent solely
22 for the purpose of receiving service of legal doc-
23 uments or process;

24 “(C) to submit to an examination of its fi-
25 nancial condition by the State insurance com-

1 missioner in any State in which the issuer is
2 doing business to determine the issuer’s finan-
3 cial condition, if—

4 “(i) the State insurance commissioner
5 of the primary State has not done an ex-
6 amination within the period recommended
7 by the National Association of Insurance
8 Commissioners; and

9 “(ii) any such examination is con-
10 ducted in accordance with the examiners’
11 handbook of the National Association of
12 Insurance Commissioners and is coordi-
13 nated to avoid unjustified duplication and
14 unjustified repetition;

15 “(D) to comply with a lawful order
16 issued—

17 “(i) in a delinquency proceeding com-
18 menced by the State insurance commis-
19 sioner if there has been a finding of finan-
20 cial impairment under subparagraph (C);
21 or

22 “(ii) in a voluntary dissolution pro-
23 ceeding;

24 “(E) to comply with an injunction issued
25 by a court of competent jurisdiction, upon a pe-

1 tition by the State insurance commissioner al-
2 leging that the issuer is in hazardous financial
3 condition;

4 “(F) to participate, on a nondiscriminatory
5 basis, in any insurance insolvency guaranty as-
6 sociation or similar association to which a
7 health insurance issuer in the State is required
8 to belong;

9 “(G) to comply with any State law regard-
10 ing fraud and abuse (as defined in section
11 2795(10)), except that if the State seeks an in-
12 junction regarding the conduct described in this
13 subparagraph, such injunction must be obtained
14 from a court of competent jurisdiction;

15 “(H) to comply with any State law regard-
16 ing unfair claims settlement practices (as de-
17 fined in section 2795(9)); or

18 “(I) to comply with the applicable require-
19 ments for independent review under section
20 2798 with respect to coverage offered in the
21 State;

22 “(2) require any individual or group health in-
23 surance coverage issued by the issuer to be counter-
24 signed by an insurance agent or broker residing in
25 that Secondary State; or

1 “(3) otherwise discriminate against the issuer
2 issuing insurance in both the primary State and in
3 any secondary State.

4 “(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A
5 health insurance issuer shall provide the following notice,
6 in 12-point bold type, in any insurance coverage offered
7 in a secondary State under this part by such a health in-
8 surance issuer and at renewal of the policy, with the 5
9 blank spaces therein being appropriately filled with the
10 name of the health insurance issuer, the name of primary
11 State, the name of the secondary State, the name of the
12 secondary State, and the name of the secondary State, re-
13 spectively, for the coverage concerned: ‘Notice: This policy
14 is issued by _____ and is governed by the laws and
15 regulations of the State of _____, and it has met all
16 the laws of that State as determined by that State’s De-
17 partment of Insurance. This policy may be less expensive
18 than others because it is not subject to all of the insurance
19 laws and regulations of the State of _____, includ-
20 ing coverage of some services or benefits mandated by the
21 law of the State of _____. Additionally, this policy
22 is not subject to all of the consumer protection laws or
23 restrictions on rate changes of the State of _____.
24 As with all insurance products, before purchasing this pol-
25 icy, you should carefully review the policy and determine

1 what health care services the policy covers and what bene-
2 fits it provides, including any exclusions, limitations, or
3 conditions for such services or benefits.’.

4 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS
5 AND PREMIUM INCREASES.—

6 “(1) IN GENERAL.—For purposes of this sec-
7 tion, a health insurance issuer that provides indi-
8 vidual or group health insurance coverage to an indi-
9 vidual under this part in a primary or secondary
10 State may not upon renewal—

11 “(A) move or reclassify the individual in-
12 sured under the health insurance coverage from
13 the class such individual is in at the time of
14 issue of the contract based on the health status-
15 related factors of the individual; or

16 “(B) increase the premiums assessed the
17 individual for such coverage based on a health
18 status-related factor or change of a health sta-
19 tus-related factor or the past or prospective
20 claim experience of the insured individual.

21 “(2) CONSTRUCTION.—Nothing in paragraph
22 (1) shall be construed to prohibit a health insurance
23 issuer—

1 “(A) from terminating or discontinuing
2 coverage or a class of coverage in accordance
3 with subsections (b) and (c) of section 2742;

4 “(B) from raising premium rates for all
5 policy holders within a class based on claims ex-
6 perience;

7 “(C) from changing premiums or offering
8 discounted premiums to individuals who engage
9 in wellness activities at intervals prescribed by
10 the issuer, if such premium changes or incen-
11 tives—

12 “(i) are disclosed to the consumer in
13 the insurance contract;

14 “(ii) are based on specific wellness ac-
15 tivities that are not applicable to all indi-
16 viduals; and

17 “(iii) are not obtainable by all individ-
18 uals to whom coverage is offered;

19 “(D) from reinstating lapsed coverage; or

20 “(E) from retroactively adjusting the rates
21 charged an insured individual if the initial rates
22 were set based on material misrepresentation by
23 the individual at the time of issue.

24 “(e) PRIOR OFFERING OF POLICY IN PRIMARY
25 STATE.—A health insurance issuer may not offer for sale

1 individual or group health insurance coverage in a sec-
2 ondary State unless that coverage is currently offered for
3 sale in the primary State.

4 “(f) LICENSING OF AGENTS OR BROKERS FOR
5 HEALTH INSURANCE ISSUERS.—Any State may require
6 that a person acting, or offering to act, as an agent or
7 broker for a health insurance issuer with respect to the
8 offering of individual or group health insurance coverage
9 obtain a license from that State, with commissions or
10 other compensation subject to the provisions of the laws
11 of that State, except that a State may not impose any
12 qualification or requirement which discriminates against
13 a nonresident agent or broker.

14 “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-
15 SURANCE COMMISSIONER.—Each health insurance issuer
16 issuing individual or group health insurance coverage in
17 both primary and secondary States shall submit—

18 “(1) to the insurance commissioner of each
19 State in which it intends to offer such coverage, be-
20 fore it may offer individual or group health insur-
21 ance coverage in such State—

22 “(A) a copy of the plan of operation or fea-
23 sibility study or any similar statement of the
24 policy being offered and its coverage (which

1 shall include the name of its primary State and
2 its principal place of business);

3 “(B) written notice of any change in its
4 designation of its primary State; and

5 “(C) written notice from the issuer of the
6 issuer’s compliance with all the laws of the pri-
7 mary State; and

8 “(2) to the insurance commissioner of each sec-
9 ondary State in which it offers individual or group
10 health insurance coverage, a copy of the issuer’s
11 quarterly financial statement submitted to the pri-
12 mary State, which statement shall be certified by an
13 independent public accountant and contain a state-
14 ment of opinion on loss and loss adjustment expense
15 reserves made by—

16 “(A) a member of the American Academy
17 of Actuaries; or

18 “(B) a qualified loss reserve specialist.

19 “(h) POWER OF COURTS TO ENJOIN CONDUCT.—
20 Nothing in this section shall be construed to affect the
21 authority of any Federal or State court to enjoin—

22 “(1) the solicitation or sale of individual or
23 group health insurance coverage by a health insur-
24 ance issuer to any person or group who is not eligi-
25 ble for such insurance; or

1 “(2) the solicitation or sale of individual or
2 group health insurance coverage that violates the re-
3 quirements of the law of a secondary State which
4 are described in subparagraphs (A) through (H) of
5 section 2796(b)(1).

6 “(i) POWER OF SECONDARY STATES TO TAKE AD-
7 MINISTRATIVE ACTION.—Nothing in this section shall be
8 construed to affect the authority of any State to enjoin
9 conduct in violation of that State’s laws described in sec-
10 tion 2796(b)(1).

11 “(j) STATE POWERS TO ENFORCE STATE LAWS.—

12 “(1) IN GENERAL.—Subject to the provisions of
13 subsection (b)(1)(G) (relating to injunctions) and
14 paragraph (2), nothing in this section shall be con-
15 strued to affect the authority of any State to make
16 use of any of its powers to enforce the laws of such
17 State with respect to which a health insurance issuer
18 is not exempt under subsection (b).

19 “(2) COURTS OF COMPETENT JURISDICTION.—

20 If a State seeks an injunction regarding the conduct
21 described in paragraphs (1) and (2) of subsection
22 (h), such injunction must be obtained from a Fed-
23 eral or State court of competent jurisdiction.

1 “(k) STATES’ AUTHORITY TO SUE.—Nothing in this
2 section shall affect the authority of any State to bring ac-
3 tion in any Federal or State court.

4 “(l) GENERALLY APPLICABLE LAWS.—Nothing in
5 this section shall be construed to affect the applicability
6 of State laws generally applicable to persons or corpora-
7 tions.

8 “(m) GUARANTEED AVAILABILITY OF COVERAGE TO
9 HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a
10 health insurance issuer is offering coverage in a primary
11 State that does not accommodate residents of secondary
12 States or does not provide a working mechanism for resi-
13 dents of a secondary State, and the issuer is offering cov-
14 erage under this part in such secondary State which has
15 not adopted a qualified high risk pool as its acceptable
16 alternative mechanism (as defined in section 2744(c)(2)),
17 the issuer shall, with respect to any individual or group
18 health insurance coverage offered in a secondary State
19 under this part, comply with the guaranteed availability
20 requirements for eligible individuals in section 2741.

21 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**
22 **BEFORE ISSUER MAY SELL INTO SECONDARY**
23 **STATES.**

24 “A health insurance issuer may not offer, sell, or
25 issue individual or group health insurance coverage in a

1 secondary State if the State insurance commissioner does
2 not use a risk-based capital formula for the determination
3 of capital and surplus requirements for all health insur-
4 ance issuers.

5 **“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCE-**
6 **DURES.**

7 “(a) **RIGHT TO EXTERNAL APPEAL.**—A health insur-
8 ance issuer may not offer, sell, or issue individual or group
9 health insurance coverage in a secondary State under the
10 provisions of this title unless—

11 “(1) both the secondary State and the primary
12 State have legislation or regulations in place estab-
13 lishing an independent review process for individuals
14 who are covered by individual health insurance cov-
15 erage or group health insurance offered by a health
16 insurance issuer, respectively, or

17 “(2) in any case in which the requirements of
18 subparagraph (A) are not met with respect to the ei-
19 ther of such States, the issuer provides an inde-
20 pendent review mechanism substantially identical (as
21 determined by the applicable State authority of such
22 State) to that prescribed in the ‘Health Carrier Ex-
23 ternal Review Model Act’ of the National Association
24 of Insurance Commissioners for all individuals who
25 purchase insurance coverage under the terms of this

1 part, except that, under such mechanism, the review
2 is conducted by an independent medical reviewer, or
3 a panel of such reviewers, with respect to whom the
4 requirements of subsection (b) are met.

5 “(b) QUALIFICATIONS OF INDEPENDENT MEDICAL
6 REVIEWERS.—In the case of any independent review
7 mechanism referred to in subsection (a)(2):

8 “(1) IN GENERAL.—In referring a denial of a
9 claim to an independent medical reviewer, or to any
10 panel of such reviewers, to conduct independent
11 medical review, the issuer shall ensure that—

12 “(A) each independent medical reviewer
13 meets the qualifications described in paragraphs
14 (2) and (3);

15 “(B) with respect to each review, each re-
16 viewer meets the requirements of paragraph (4)
17 and the reviewer, or at least 1 reviewer on the
18 panel, meets the requirements described in
19 paragraph (5); and

20 “(C) compensation provided by the issuer
21 to each reviewer is consistent with paragraph
22 (6).

23 “(2) LICENSURE AND EXPERTISE.—Each inde-
24 pendent medical reviewer shall be a physician

1 (allopathic or osteopathic) or health care profes-
2 sional who—

3 “(A) is appropriately credentialed or li-
4 censed in 1 or more States to deliver health
5 care services; and

6 “(B) typically treats the condition, makes
7 the diagnosis, or provides the type of treatment
8 under review.

9 “(3) INDEPENDENCE.—

10 “(A) IN GENERAL.—Subject to subpara-
11 graph (B), each independent medical reviewer
12 in a case shall—

13 “(i) not be a related party (as defined
14 in paragraph (7));

15 “(ii) not have a material familial, fi-
16 nancial, or professional relationship with
17 such a party; and

18 “(iii) not otherwise have a conflict of
19 interest with such a party (as determined
20 under regulations).

21 “(B) EXCEPTION.—Nothing in subpara-
22 graph (A) shall be construed to—

23 “(i) prohibit an individual, solely on
24 the basis of affiliation with the issuer,

1 from serving as an independent medical re-
2 viewer if—

3 “(I) a non-affiliated individual is
4 not reasonably available;

5 “(II) the affiliated individual is
6 not involved in the provision of items
7 or services in the case under review;

8 “(III) the fact of such an affili-
9 ation is disclosed to the issuer and the
10 enrollee (or authorized representative)
11 and neither party objects; and

12 “(IV) the affiliated individual is
13 not an employee of the issuer and
14 does not provide services exclusively or
15 primarily to or on behalf of the issuer;

16 “(ii) prohibit an individual who has
17 staff privileges at the institution where the
18 treatment involved takes place from serv-
19 ing as an independent medical reviewer
20 merely on the basis of such affiliation if
21 the affiliation is disclosed to the issuer and
22 the enrollee (or authorized representative),
23 and neither party objects; or

24 “(iii) prohibit receipt of compensation
25 by an independent medical reviewer from

1 an entity if the compensation is provided
2 consistent with paragraph (6).

3 “(4) PRACTICING HEALTH CARE PROFESSIONAL
4 IN SAME FIELD.—

5 “(A) IN GENERAL.—In a case involving
6 treatment, or the provision of items or serv-
7 ices—

8 “(i) by a physician, a reviewer shall be
9 a practicing physician (allopathic or osteo-
10 pathic) of the same or similar specialty, as
11 a physician who, acting within the appro-
12 priate scope of practice within the State in
13 which the service is provided or rendered,
14 typically treats the condition, makes the
15 diagnosis, or provides the type of treat-
16 ment under review; or

17 “(ii) by a non-physician health care
18 professional, the reviewer, or at least 1
19 member of the review panel, shall be a
20 practicing non-physician health care pro-
21 fessional of the same or similar specialty
22 as the non-physician health care profes-
23 sional who, acting within the appropriate
24 scope of practice within the State in which
25 the service is provided or rendered, typi-

1 cally treats the condition, makes the diag-
2 nosis, or provides the type of treatment
3 under review.

4 “(B) PRACTICING DEFINED.—For pur-
5 poses of this paragraph, the term ‘practicing’
6 means, with respect to an individual who is a
7 physician or other health care professional, that
8 the individual provides health care services to
9 individual patients on average at least 2 days
10 per week.

11 “(5) PEDIATRIC EXPERTISE.—In the case of an
12 external review relating to a child, a reviewer shall
13 have expertise under paragraph (2) in pediatrics.

14 “(6) LIMITATIONS ON REVIEWER COMPENSA-
15 TION.—Compensation provided by the issuer to an
16 independent medical reviewer in connection with a
17 review under this section shall—

18 “(A) not exceed a reasonable level; and

19 “(B) not be contingent on the decision ren-
20 dered by the reviewer.

21 “(7) RELATED PARTY DEFINED.—For purposes
22 of this section, the term ‘related party’ means, with
23 respect to a denial of a claim under a coverage relat-
24 ing to an enrollee, any of the following:

1 “(A) The issuer involved, or any fiduciary,
2 officer, director, or employee of the issuer.

3 “(B) The enrollee (or authorized represent-
4 ative).

5 “(C) The health care professional that pro-
6 vides the items or services involved in the de-
7 nial.

8 “(D) The institution at which the items or
9 services (or treatment) involved in the denial
10 are provided.

11 “(E) The manufacturer of any drug or
12 other item that is included in the items or serv-
13 ices involved in the denial.

14 “(F) Any other party determined under
15 any regulations to have a substantial interest in
16 the denial involved.

17 “(8) DEFINITIONS.—For purposes of this sub-
18 section:

19 “(A) ENROLLEE.—The term ‘enrollee’
20 means, with respect to health insurance cov-
21 erage offered by a health insurance issuer, an
22 individual enrolled with the issuer to receive
23 such coverage.

24 “(B) HEALTH CARE PROFESSIONAL.—The
25 term ‘health care professional’ means an indi-

1 individual who is licensed, accredited, or certified
2 under State law to provide specified health care
3 services and who is operating within the scope
4 of such licensure, accreditation, or certification.

5 **“SEC. 2799. ENFORCEMENT.**

6 “(a) IN GENERAL.—Subject to subsection (b), with
7 respect to specific individual or group health insurance
8 coverage the primary State for such coverage has sole ju-
9 risdiction to enforce the primary State’s covered laws in
10 the primary State and any secondary State.

11 “(b) SECONDARY STATE’S AUTHORITY.—Nothing in
12 subsection (a) shall be construed to affect the authority
13 of a secondary State to enforce its laws as set forth in
14 the exception specified in section 2796(b)(1).

15 “(c) COURT INTERPRETATION.—In reviewing action
16 initiated by the applicable secondary State authority, the
17 court of competent jurisdiction shall apply the covered
18 laws of the primary State.

19 “(d) NOTICE OF COMPLIANCE FAILURE.—In the case
20 of individual health insurance coverage offered in a sec-
21 ondary State, or group health insurance covered offered
22 by a health insurance issuer in a secondary State, that
23 fails to comply with the covered laws of the primary State,
24 the applicable State authority of the secondary State may

1 notify the applicable State authority of the primary
2 State.”.

3 (b) EFFECTIVE DATE.—The amendment made by
4 subsection (a) shall apply to health insurance coverage of-
5 fered, issued, or sold after the date that is one year after
6 the date of the enactment of this Act.

7 (c) GAO ONGOING STUDY AND REPORTS.—

8 (1) STUDY.—The Comptroller General of the
9 United States shall conduct an ongoing study con-
10 cerning the effect of the amendment made by sub-
11 section (a) on—

12 (A) the number of uninsured and under-in-
13 sured;

14 (B) the availability and cost of health in-
15 surance policies for individuals with pre-existing
16 medical conditions;

17 (C) the availability and cost of health in-
18 surance policies generally;

19 (D) the elimination or reduction of dif-
20 ferent types of benefits under health insurance
21 policies offered in different States; and

22 (E) cases of fraud or abuse relating to
23 health insurance coverage offered under such
24 amendment and the resolution of such cases.

1 (2) ANNUAL REPORTS.—The Comptroller Gen-
2 eral shall submit to Congress an annual report, after
3 the end of each of the 5 years following the effective
4 date of the amendment made by subsection (a), on
5 the ongoing study conducted under paragraph (1).

6 **SEC. 502. CONTINUING STATE AUTHORITY.**

7 Nothing in this title, or the amendments made by this
8 title, shall be construed as preventing a State—

9 (1) from permitting residents of the State to
10 purchase of health insurance offered by a health in-
11 surance issuer located outside the State; or

12 (2) from permitting groups to directly obtain,
13 through an association health plan or otherwise,
14 health insurance coverage for their members.

15 **TITLE VI—STATE HEALTH**
16 **FLEXIBILITY**

17 **SEC. 601. SHORT TITLE.**

18 This title may be cited as the “State Health Flexi-
19 bility Act of 2013”.

20 **SEC. 602. HEALTH GRANTS TO THE STATES FOR HEALTH**
21 **CARE SERVICES TO INDIGENT INDIVIDUALS.**

22 (a) HEALTH CARE BLOCK GRANT TO STATES.—The
23 Social Security Act is amended by adding at the end the
24 following new title:

1 **“TITLE XXII—BLOCK GRANTS TO**
2 **STATES FOR HEALTH CARE**
3 **SERVICES TO INDIGENT INDI-**
4 **VIDUALS**

5 **“SEC. 2201. PURPOSE.**

6 “The purpose of this title is to provide Federal finan-
7 cial assistance to the States, in the form of a single grant,
8 to allow the States maximum flexibility in providing, and
9 financing the provision of, health-care-related items and
10 services to indigent individuals.

11 **“SEC. 2202. GRANTS TO STATES.**

12 “(a) IN GENERAL.—Subject to the requirements of
13 this title, each State is entitled to receive from the Sec-
14 retary of the Treasury a grant for each quarter of fiscal
15 years 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021,
16 2022, and 2023, in an amount that is equal to 25 percent
17 of the total amount received by a State under title XIX
18 and title XXI for fiscal year 2012.

19 “(b) APPROPRIATION.—Out of any money in the
20 Treasury of the United States not otherwise appropriated,
21 there are appropriated for fiscal years 2014, 2015, 2016,
22 2017, 2018, 2019, 2020, 2021, 2022, and 2023 such sums
23 as are necessary for grants under this section.

24 “(c) REQUIREMENTS RELATING TO INTERGOVERN-
25 MENTAL FINANCING.—The Secretary of the Treasury

1 shall make the transfer of funds under grants under sub-
2 section (a) directly to each State in accordance with the
3 requirements of section 6503 of title 31, United States
4 Code.

5 “(d) EXPENDITURE OF FUNDS.—

6 “(1) IN GENERAL.—Except as provided in para-
7 graph (2), amounts received by a State under this
8 title for any fiscal year shall be expended by the
9 State in such fiscal year or in the succeeding fiscal
10 year.

11 “(2) USE OF RAINY DAY FUND PERMITTED.—

12 Of the amounts received by a State under this title,
13 the State may set aside, in a separate account, such
14 amounts as the State deems necessary to provide,
15 without fiscal limitation, health-care-related items
16 and services for indigent individuals during—

17 “(A) periods of unexpectedly high rates of
18 unemployment; or

19 “(B) periods related to circumstances that
20 are not described in subparagraph (A) and that
21 cause unexpected increases in the need for such
22 items and services for such individuals.

23 “(3) FUNDS REMAINING AFTER FISCAL YEAR
24 2022.—If, after fiscal year 2023, a State has funds
25 in the account under paragraph (2), the State may

1 only expend such funds if such funds are used in a
2 manner that is permitted under subsection (e), as
3 such subsection is in effect on September 30, 2023.

4 “(e) USE OF FUNDS.—A State may only use the
5 amounts received under subsection (a) as follows:

6 “(1) GENERAL PURPOSE.—For the purpose
7 under section 2201, including the provision of
8 health-care-related items and services as required
9 under section 2205. Nothing in this title shall be
10 construed as limiting the flexibility of a State to de-
11 termine which providers of such items and services
12 qualify to receive payment from a grant made to the
13 State under this title.

14 “(2) FUNDING FOR RISK ADJUSTMENT MECHA-
15 NISMS.—To fund qualified high risk pools, reinsur-
16 ance pools, or other risk-adjustment mechanisms
17 used for the purpose of subsidizing the purchase of
18 private health insurance for the high-risk population.

19 “(3) AUTHORITY TO USE PORTION OF FEDERAL
20 ASSISTANCE FOR OTHER WELFARE-RELATED PRO-
21 GRAMS.—

22 “(A) IN GENERAL.—Subject to the limit
23 under subparagraph (B), to carry out a State
24 program pursuant to any or all of the following
25 provisions of law:

1 “(i) Part A of title IV of this Act.

2 “(ii) Section 1616 of this Act.

3 “(iii) The Food and Nutrition Act of
4 2008.

5 “(B) LIMITATION.—A State may not use
6 more than 30 percent of the amount received
7 under subsection (a) for a fiscal year to carry
8 out a State program, or programs, under sub-
9 paragraph (A).

10 “(C) REQUIREMENTS ON FUNDS.—Any
11 amounts that are used under subparagraph
12 (A)—

13 “(i) shall not be subject to any of the
14 requirements of subsection (d), subsection
15 (f), section 2204, or section 2205; and

16 “(ii) shall be subject to—

17 “(I) the audit requirements
18 under section 2203; and

19 “(II) any requirements that
20 apply to Federal funds provided di-
21 rectly for such State program.

22 “(f) MAINTENANCE OF CURRENT LAW RESTRIC-
23 TIONS ON USE OF FEDERAL FUNDS.—

24 “(1) IN GENERAL.—

1 “(A) NO FUNDING FOR ABORTIONS.—
2 None of the funds appropriated in this title
3 shall be expended for any abortion.

4 “(B) NO FUNDS FOR COVERAGE OF ABOR-
5 TION.—None of the funds appropriated in this
6 title shall be expended for health benefits cov-
7 erage that includes coverage of abortion.

8 “(C) HEALTH BENEFITS COVERAGE DE-
9 FINED.—For purposes of this subsection, the
10 term ‘health benefits coverage’ means the pack-
11 age of services covered by a managed care pro-
12 vider or organization pursuant to a contract or
13 other arrangement.

14 “(2) EXCEPTIONS.—The limitations established
15 in paragraph (1) shall not apply to an abortion in
16 the case where a woman suffers from a physical dis-
17 order, physical injury, or physical illness that would,
18 as certified by a physician, place the woman in dan-
19 ger of death unless an abortion is performed, includ-
20 ing a life-endangering physical condition caused by
21 or arising from the pregnancy itself.

22 “(3) STATE FUNDS USED IN CONJUNCTION
23 WITH FEDERAL FUNDS.—The limitations established
24 in paragraph (1) shall apply to any State funds used
25 in conjunction with Federal funds appropriated

1 under this title to provide, or finance the provision
2 of, health-care-related items and services to indigent
3 individuals pursuant to section 2201 or subsections
4 (d)(2), (e)(1), or (e)(2) of this section.

5 “(4) OPTION TO PURCHASE SEPARATE COV-
6 ERAGE OR PLAN.—Nothing in this subsection shall
7 be construed as prohibiting a State from purchasing
8 separate coverage for abortions for which funding is
9 prohibited under this subsection, or a health plan
10 that includes such abortions, so long as such cov-
11 erage or plan is paid for entirely using funds not
12 provided by this title.

13 “(5) OPTION TO OFFER COVERAGE OR PLAN.—
14 Nothing in this subsection shall restrict any health
15 insurance issuer from offering separate coverage for
16 abortions for which funding is prohibited under this
17 subsection, or a health plan that includes such abor-
18 tions, so long as—

19 “(A) premiums for such separate coverage
20 or plan are paid entirely with funds not pro-
21 vided by this title; and

22 “(B) administrative costs and all services
23 offered through such separate coverage or plan
24 are paid for using only premiums collected for
25 such coverage or plan.

1 “(6) CONSCIENCE PROTECTIONS.—

2 “(A) None of the funds appropriated in
3 this Act may be made available to a Federal
4 agency or program, or to a State or local gov-
5 ernment, if such agency, program, or govern-
6 ment subjects any institutional or individual
7 health care entity to discrimination on the basis
8 that the health care entity does not provide, pay
9 for, provide coverage of, or refer for abortions.

10 “(B) In this paragraph, the term ‘health
11 care entity’ includes an individual physician,
12 pharmacist, or other health care professional, a
13 hospital, a provider-sponsored organization, a
14 health maintenance organization, a health in-
15 surance plan, or any other kind of health care
16 facility, organization, or plan.

17 “(g) NO FUNDING FOR ILLEGAL ALIENS.—Except as
18 provided under this section and section 2205, no funds
19 appropriated in this title may be used to provide health-
20 care-related items and services to an alien who is not law-
21 fully admitted for permanent residence or otherwise per-
22 manently residing in the United States under color of law.

23 “(h) NONENTITLEMENT.—Nothing in this title shall
24 be construed as providing an individual with an entitle-

1 ment to health-care-related items and services under this
2 title.

3 **“SEC. 2203. ADMINISTRATIVE AND FISCAL ACCOUNT-**
4 **ABILITY.**

5 “(a) AUDITS.—

6 “(1) CONTRACT WITH APPROVED AUDITING EN-
7 TITY.—Not later than October 1, 2014, and annu-
8 ally thereafter, a State shall contract with an ap-
9 proved auditing entity (as defined under paragraph
10 (3)(B)) for purposes of conducting an audit under
11 paragraph (2) (with respect to the fiscal year ending
12 September 30 of such year).

13 “(2) AUDIT REQUIREMENT.—Under a contract
14 under paragraph (1), an approved auditing entity
15 shall conduct an audit of the expenditures or trans-
16 fers made by a State from amounts received under
17 a grant under this title, or from State funds de-
18 scribed in section 2202(f)(3), with respect to the fis-
19 cal year which such audit covers, to determine the
20 extent to which such expenditures and transfers
21 were expended in accordance with this title.

22 “(3) ENTITY CONDUCTING AUDIT.—

23 “(A) IN GENERAL.—With respect to a
24 State, the audit under paragraph (2) shall be
25 conducted by an approved auditing entity in ac-

1 cordance with generally accepted auditing prin-
2 ciples.

3 “(B) APPROVED AUDITING ENTITY.—For
4 purposes of this section, the term ‘approved au-
5 diting entity’ means, with respect to a State, an
6 entity that is—

7 “(i) approved by the Secretary of the
8 Treasury;

9 “(ii) approved by the chief executive
10 officer of the State; and

11 “(iii) independent of any Federal,
12 State, or local agency.

13 “(4) SUBMISSION OF AUDIT.—Not later than
14 December 31, 2014, and annually thereafter, a State
15 shall submit the results of the audit under para-
16 graph (2) (with respect to the fiscal year ending on
17 September 30 of such year) to the State legislature
18 and to the Secretary of the Treasury.

19 “(5) ADDITIONAL ACCOUNTING REQUIRE-
20 MENTS.—The provisions of chapter 75 of title 31,
21 United States Code, shall apply to the audit require-
22 ments of this section.

23 “(b) REIMBURSEMENT AND PENALTY.—

24 “(1) IN GENERAL.—If, through an audit con-
25 ducted under subsection (a), an approved auditing

1 entity finds that any amounts paid to a State under
2 a grant under this title were not expended in accord-
3 ance with this title—

4 “(A) the State shall pay to the Treasury of
5 the United States any such amount, plus 10
6 percent of such amount as a penalty; or

7 “(B) the Secretary of the Treasury shall
8 offset such amount plus the 10 percent penalty
9 against any other amount in any other fiscal
10 year that the State may be entitled to receive
11 under a grant under this title.

12 “(2) MISUSE OF STATE FUNDS.—If, through an
13 audit conducted under subsection (a), an approved
14 auditing entity finds that a State violated the re-
15 quirements of section 2202(f)(3), the State shall pay
16 to the Treasury of the United States 100 percent of
17 the amount of State funds that were used in viola-
18 tion of section 2202(f)(3) as a penalty. Insofar as a
19 State fails to pay any such penalty, the Secretary of
20 the Treasury shall offset the amount not so paid
21 against the amount of any grant otherwise payable
22 to the State under this title.

23 “(c) ANNUAL REPORTING REQUIREMENTS.—

24 “(1) IN GENERAL.—Not later than January 31,
25 2015, and annually thereafter, each State shall sub-

1 mit to the Secretary of the Treasury and the State
2 legislature a report on the activities carried out by
3 the State during the most recently completed fiscal
4 year with funds received by the State under a grant
5 under this title for such fiscal year.

6 “(2) CONTENT.—A report under paragraph (1)
7 shall, with respect to a fiscal year—

8 “(A) contain the results of the audit con-
9 ducted by an approved auditing entity for a
10 State for such fiscal year, in accordance with
11 the requirements of subsection (a) of this sec-
12 tion;

13 “(B) specify the amount of the grant made
14 to the State under this title that is used to
15 carry out a program under section 2202(e)(3);
16 and

17 “(C) be in such form and contain such
18 other information as the State determines is
19 necessary to provide—

20 “(i) an accurate description of the ac-
21 tivities conducted by the State for the pur-
22 pose described under section 2201 and any
23 other use of funds permitted under sub-
24 sections (d) and (e) of section 2202; and

1 “(ii) a complete record of the pur-
2 poses for which amounts were expended in
3 accordance with this title.

4 “(3) CONFORMITY WITH ACCOUNTING PRIN-
5 CIPALS.—Any financial information in the report
6 under paragraph (1) shall be prepared and reported
7 in accordance with generally accepted accounting
8 principles, including the provisions of chapter 75 of
9 title 31, United States Code.

10 “(4) PUBLIC AVAILABILITY.—A State shall
11 make copies of the reports required under this sec-
12 tion available on a public Web site and shall make
13 copies available in other formats upon request.

14 “(d) FAILURE TO COMPLY WITH REQUIREMENTS.—
15 The Secretary of the Treasury shall not make any pay-
16 ment to a State under a grant authorized by section
17 2202(a)—

18 “(1) if an audit for a State is not submitted as
19 required under subsection (a), during the period be-
20 tween the date such audit is due and the date on
21 which such audit is submitted;

22 “(2) if a State fails to submit a report as re-
23 quired under subsection (c), during the period be-
24 tween the date such report is due and the date on
25 which such report is submitted; or

1 “(3) if a State violates a requirement of section
2 2202(f), during the period beginning on the date the
3 Secretary becomes aware of such violation and the
4 date on which such violation is corrected by the
5 State.

6 “(e) ADMINISTRATIVE SUPERVISION AND OVER-
7 SIGHT.—

8 “(1) LIMITED ROLE FOR SECRETARY OF TREAS-
9 URY AND THE ATTORNEY GENERAL.—

10 “(A) TREASURY.—The authority of the
11 Secretary of the Treasury under this title is
12 limited to—

13 “(i) promulgating regulations, issuing
14 rules, or publishing guidance documents to
15 the extent necessary for purposes of imple-
16 menting subsection (a)(3)(B), subsection
17 (b), and subsection (d);

18 “(ii) making quarterly payments to
19 the States under grants under this title in
20 accordance with section 2202(a);

21 “(iii) approving entities under sub-
22 section (a)(3)(B) for purposes of the audits
23 required under subsection (a);

24 “(iv) withholding payment to a State
25 of a grant under subsection (d) or offset-

1 ting a payment of such a grant to a State
2 under subsection (b); and

3 “(v) exercising the authority relating
4 to nondiscrimination that is specified in
5 section 2204(b).

6 “(B) ATTORNEY GENERAL.—The authority
7 of the Attorney General to supervise the
8 amounts received by a State under this title is
9 limited to the authority under section 2204(e).

10 “(2) FEDERAL SUPERVISION.—

11 “(A) IN GENERAL.—Except as provided
12 under paragraph (1), an administrative officer,
13 employee, department, or agency of the United
14 States (including the Secretary of Health and
15 Human Services) may not—

16 “(i) supervise—

17 “(I) the amounts received by the
18 States under this title; or

19 “(II) the use of such amounts by
20 the States; or

21 “(ii) promulgate regulations or issue
22 rules in accordance with this title.

23 “(B) LIMITATION ON SECRETARY OF
24 HEALTH AND HUMAN SERVICES.—The Sec-
25 retary of Health and Human Services shall

1 have no authority over any provision of this
2 title.

3 “(f) RESERVATION OF STATE POWERS.—Nothing in
4 this section shall be construed to limit the power of a
5 State, including the power of a State to pursue civil and
6 criminal penalties under State law against any individual
7 or entity that misuses, or engages in fraud or abuse re-
8 lated to, the funds provided to a State under this title.

9 **“SEC. 2204. NONDISCRIMINATION PROVISIONS.**

10 “(a) NO DISCRIMINATION AGAINST INDIVIDUALS.—
11 No individual shall be excluded from participation in, de-
12 nied the benefits of, or subjected to discrimination under,
13 any program or activity funded in whole or in part with
14 amounts paid to a State under this title on the basis of
15 such individual’s—

16 “(1) disability under section 504 of the Reha-
17 bilitation Act of 1973 (29 U.S.C. 794);

18 “(2) sex under title IX of the Education
19 Amendments of 1972 (20 U.S.C. 1681 et seq.); or

20 “(3) race, color, or national origin under title
21 VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d
22 et seq.).

23 “(b) COMPLIANCE.—

24 “(1) If the Secretary of the Treasury deter-
25 mines that a State or an entity that has received

1 funds from amounts paid to a State under a grant
2 under this title has failed to comply with a provision
3 of law referred to in subsection (a), the Secretary of
4 the Treasury shall notify the chief executive officer
5 of the State of such failure to comply and shall re-
6 quest that such chief executive officer secure such
7 compliance.

8 “(2) If, not later than 60 days after receiving
9 notification under paragraph (1), the chief executive
10 officer of a State fails or refuses to secure compli-
11 ance with the provision of law referred to in such
12 notification, the Secretary of the Treasury may—

13 “(A) refer the matter to the Attorney Gen-
14 eral with a recommendation that an appropriate
15 civil action be instituted; or

16 “(B) exercise the powers and functions
17 provided under section 505 of the Rehabilita-
18 tion Act of 1973 (29 U.S.C. 794a), title IX of
19 the Education Amendments of 1972 (20 U.S.C.
20 1681 et seq.), or title VI of the Civil Rights Act
21 of 1964 (42 U.S.C. 2000d et seq.) (as applica-
22 ble).

23 “(c) CIVIL ACTIONS.—If a matter is referred to the
24 Attorney General under subsection (b)(2)(A), or the At-
25 torney General has reason to believe that a State or entity

1 has failed to comply with a provision of law referred to
2 in subsection (a), the Attorney General may bring a civil
3 action in an appropriate district court of the United States
4 for such relief as may be appropriate, including injunctive
5 relief.

6 **“SEC. 2205. EMERGENCY ASSISTANCE.**

7 “(a) IN GENERAL.—A State that receives a grant
8 under this title for a fiscal year shall provide payment for
9 health-care-related items and services provided to a cit-
10 izen, legal resident, or an alien who is not lawfully admit-
11 ted for permanent residence or otherwise permanently re-
12 siding in the United States under color of law, consistent
13 with the requirements of section 1867, if—

14 “(1) such health-care-related items and services
15 are—

16 “(A) necessary for the treatment of an
17 emergency medical condition; and

18 “(B) health-care-related items and services
19 that such State would provide payment for
20 under this title, if provided to an indigent indi-
21 vidual;

22 “(2) the individual meets all necessary eligi-
23 bility requirements for health-care-related items and
24 services under the State program funded under this

1 title, except for any requirement related to immigra-
2 tion status; and

3 “(3) such items and services are not related to
4 an organ transplant procedure.

5 “(b) EMERGENCY MEDICAL CONDITION.—For pur-
6 poses of this section, the term ‘emergency medical condi-
7 tion’ means a medical condition (including emergency
8 labor and delivery) manifesting itself by acute symptoms
9 of sufficient severity (including severe pain) such that the
10 absence of immediate medical attention could reasonably
11 be expected to result in—

12 “(1) placing the patient’s health in serious jeop-
13 ardy;

14 “(2) serious impairment to bodily functions; or

15 “(3) serious dysfunction of any bodily organ or
16 part.

17 **“SEC. 2206. DEFINITIONS.**

18 “For purposes of this title:

19 “(1) HEALTH-CARE-RELATED ITEMS AND SERV-
20 ICES.—The term ‘health-care-related items and serv-
21 ices’ shall be defined by a State with respect to use
22 of such term for purposes of the application of this
23 title to the State.

1 “(2) HIGH-RISK POPULATION.—The term ‘high-
2 risk population’ means individuals who are described
3 in one of the following subparagraphs:

4 “(A) Individuals who, by reason of the ex-
5 istence or history of a medical condition, are
6 able to acquire health coverage only at rates
7 which are at least 150 percent of the standard
8 risk rates for such coverage.

9 “(B) Individuals who are provided health
10 coverage by a qualified high risk pool.

11 “(3) INDIGENT INDIVIDUAL.—The term ‘indi-
12 gent individual’ shall be defined by a State with re-
13 spect to use of such term for purposes of the appli-
14 cation of this title to the State.

15 “(4) QUALIFIED HIGH RISK POOL.—The term
16 ‘qualified high risk pool’ has the meaning given such
17 term in section 2745(g)(1)(A) of the Public Health
18 Service Act.

19 “(5) RISK-ADJUSTMENT MECHANISM DE-
20 FINED.—For purposes of this section, the term
21 ‘risk-adjustment mechanism’ means any risk-spread-
22 ing mechanism to subsidize the purchase of private
23 health insurance for the high-risk population, includ-
24 ing a qualified high risk pool.”.

1 (b) REPORT ON REDUCTION OF FEDERAL ADMINIS-
2 TRATIVE EXPENDITURES.—Beginning not later than Oc-
3 tober 31, 2014, and annually thereafter until October 31,
4 2023, the Secretary of Health and Human Services, in
5 consultation with the Secretary of the Treasury, shall sub-
6 mit a report to the Committee on Energy and Commerce
7 in the House of Representatives and the Finance Com-
8 mittee in the Senate containing a description of the total
9 reduction in Federal expenditures required to administer
10 and provide oversight for the programs to provide health-
11 care-related items and services to indigent individuals
12 under this Act, compared to the expenditures required to
13 administer and provide oversight for the programs under
14 titles XIX and XXI of the Social Security Act, as in effect
15 on September 30, 2012.

16 (c) STATE DEFINED.—Section 1101(a)(1) of the So-
17 cial Security Act (42 U.S.C. 1301(a)(1)) is amended—

18 (1) in the first sentence, by striking “and XXI”
19 and inserting “XXI, and XXII”; and

20 (2) in the fourth sentence, by striking “and
21 XXI” and inserting “, XXI, and XXII”.

22 **SEC. 603. REPEAL OF FEDERAL REQUIREMENTS OF MED-**
23 **ICAID AND CHIP.**

24 Titles XIX and XXI of the Social Security Act are
25 repealed.

1 **SEC. 604. SEVERABILITY.**

2 If any provision of this title, or the application of
3 such provision to any person or circumstance, is found to
4 be unconstitutional, the remainder of this title, or the ap-
5 plication of that provision to other persons or cir-
6 cumstances, shall not be affected.

7 **SEC. 605. EFFECTIVE DATE.**

8 This title and the amendments made by this title
9 shall take effect with respect to items and services fur-
10 nished on or after October 1, 2013.

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