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(Original Signature of Member)

114TH CONGRESS  
1ST SESSION

# H. R.

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To restore equity, save coverage, and undo errors in the case of individuals who lose health insurance subsidies under *King v. Burwell*, and other individuals, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

Mr. PRICE of Georgia introduced the following bill; which was referred to the Committee on \_\_\_\_\_

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# A BILL

To restore equity, save coverage, and undo errors in the case of individuals who lose health insurance subsidies under *King v. Burwell*, and other individuals, 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; CONTIN-**  
4 **GENCY AND LIMITATION ON APPLICATION.**

5 (a) SHORT TITLE.—This Act may be cited as the  
6 “Restoring Equity, Saving Coverage, and Undoing Errors

1 Act of 2015” or as the “RESCUE America’s Health Care  
2 Act of 2015”.

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

- Sec. 1. Short title; table of contents; contingency and limitation on application.
- Sec. 2. Refundable tax credit for health insurance coverage.
- Sec. 3. Restoring to States the freedom and flexibility to regulate health insurance markets.
- Sec. 4. Pool reform for individual membership expansion.
- Sec. 5. Requirements for individual health insurance.

5 (c) CONTINGENCY AND LIMITATION ON APPLICA-  
6 TION.—

7 (1) DEPENDENT UPON SUPREME COURT DE-  
8 TERMINATION IN *KING V. BURWELL*.—The suc-  
9 ceeding provisions of this Act (including the amend-  
10 ments made by this Act) shall only apply if the Su-  
11 preme Court determines that the premium tax credit  
12 under section 36B of the Internal Revenue Code of  
13 1986 is not available to individuals who are enrolled  
14 in a qualified health plan offered through the Feder-  
15 ally operated Exchange established pursuant to sec-  
16 tion 1321(c) of the Patient Protection and Afford-  
17 able Care Act (42 U.S.C. 18041(c)).

18 (2) APPLICATION IN STATES WITHOUT A  
19 STATE-OPERATED EXCHANGE.—In the case of a  
20 State that has not established an Exchange under  
21 section 1311 of the Patient Protection and Afford-  
22 able Care Act (42 U.S.C. 18031) for which a pre-

1       mium tax credit is available pursuant to section  
2       36B(b)(1)(A) of the Internal Revenue Code of 1986,  
3       as interpreted by the Supreme Court, the succeeding  
4       provisions of this Act (including the amendments  
5       made by this Act) shall apply, subject to paragraphs  
6       (1) and (4), to the State and to individuals residing  
7       in the State as of the date on which such credit be-  
8       comes no longer available to such individuals pursu-  
9       ant to the Supreme Court determination described  
10      in paragraph (1) (such date referred to in this Act  
11      as the “*King v. Burwell* effective date”) .

12           (3) OPTION OF APPLICATION IN STATES WITH  
13      A STATE-OPERATED EXCHANGE.—In the case of a  
14      State that has established an Exchange under sec-  
15      tion 1311 of the Patient Protection and Affordable  
16      Care Act (42 U.S.C. 18031) for which a premium  
17      tax credit is available pursuant to section  
18      36B(b)(1)(A) of the Internal Revenue Code of 1986,  
19      as interpreted by the Supreme Court—

20           (A) the State may at any time terminate  
21           operation of such Exchange; and

22           (B) if the State terminates operation of  
23           any such Exchange established under such sec-  
24           tion 1311, the provisions of this Act (including  
25           the amendments made by this Act) shall apply,

1 subject to paragraphs (1) and (4), to the State  
2 and to individuals residing in the State as of  
3 the date on which the operation of such Ex-  
4 change is terminated, but in no case shall such  
5 provisions and amendments apply earlier than  
6 the *King v. Burwell* effective date.

7 (4) NO APPLICATION TO STATES WITH AN EX-  
8 CHANGE FOR WHICH PREMIUM CREDIT IS AVAIL-  
9 ABLE.—The succeeding provisions of this Act (in-  
10 cluding the amendments made by this Act) shall not  
11 apply to a State and to individuals residing in a  
12 State so long as there is operating in the State an  
13 Exchange for which a premium tax credit is avail-  
14 able pursuant to section 36B(b)(1)(A) of the Inter-  
15 nal Revenue Code of 1986 to such individuals, as in-  
16 terpreted by the Supreme Court.

17 **SEC. 2. REFUNDABLE TAX CREDIT FOR HEALTH INSUR-**  
18 **ANCE COVERAGE.**

19 (a) IN GENERAL.—Subpart C of part IV of sub-  
20 chapter A of chapter 1 of the Internal Revenue Code of  
21 1986 is amended by inserting after section 36B the fol-  
22 lowing new section:

23 **“SEC. 36C. HEALTH INSURANCE COVERAGE.**

24 “(a) IN GENERAL.—In the case of an individual,  
25 there shall be allowed as a credit against the tax imposed

1 by subtitle A the aggregate monthly credit amounts deter-  
2 mined under subsection (b) with respect to the taxpayer  
3 and the taxpayer's qualifying family members for eligible  
4 coverage months beginning during the taxable year.

5 “(b) MONTHLY CREDIT AMOUNTS.—

6 “(1) IN GENERAL.—The monthly credit amount  
7 with respect to any individual for any eligible cov-  
8 erage month is  $\frac{1}{12}$  of—

9 “(A) \$900 in the case of an individual who  
10 has not attained age 18 as of the beginning of  
11 such month,

12 “(B) \$1,200 in the case of an individual  
13 who has so attained age 18 but who has not so  
14 attained age 35,

15 “(C) \$2,100 in the case of an individual  
16 who has so attained age 35, but who has not  
17 so attained age 50, and

18 “(D) \$3,000 in the case of an individual  
19 who has so attained age 50.

20 “(2) INFLATION ADJUSTMENT.—In the case of  
21 any taxable year beginning in a calendar year after  
22 2016, each dollar amount contained in paragraph  
23 (1) shall be increased by an amount equal to—

24 “(A) such dollar amount, multiplied by

1           “(B) the cost-of-living adjustment deter-  
2           mined under section 1(f)(3) for the calendar  
3           year in which the taxable year begins, deter-  
4           mined by substituting ‘calendar year 2015’ for  
5           ‘calendar year 1992’ in subparagraph (B)  
6           thereof.

7           Any increase determined under the preceding sen-  
8           tence shall be rounded to the nearest multiple of  
9           \$50.

10          “(c) ELIGIBLE COVERAGE MONTH.—For purposes of  
11 this section, the term ‘eligible coverage month’ means,  
12 with respect to any individual, any month if, as of the first  
13 day of such month, the individual—

14           “(1) is covered by qualified health insurance,  
15           “(2) does not have other specified coverage, and  
16           “(3) is not imprisoned under Federal, State, or  
17           local authority.

18          “(d) QUALIFYING FAMILY MEMBER.—For purposes  
19 of this section, the term ‘qualifying family member’  
20 means—

21           “(1) in the case of a joint return, the taxpayer’s  
22           spouse, and  
23           “(2) any dependent of the taxpayer.

24          “(e) QUALIFIED HEALTH INSURANCE.—For pur-  
25 poses of this section, the term ‘qualified health insurance’

1 means health insurance coverage (other than excepted  
2 benefits as defined in section 9832(c)) which constitutes  
3 medical care.

4 “(f) OTHER SPECIFIED COVERAGE.—For purposes of  
5 this section, an individual has other specified coverage for  
6 any month if, as of the first day of such month—

7 “(1) COVERAGE UNDER MEDICARE, MEDICAID,  
8 OR SCHIP.—Such individual—

9 “(A) is entitled to benefits under part A of  
10 title XVIII of the Social Security Act or is en-  
11 rolled under part B of such title, or

12 “(B) is enrolled in the program under title  
13 XIX or XXI of such Act (other than under sec-  
14 tion 1928 of such Act).

15 “(2) CERTAIN OTHER COVERAGE.—Such indi-  
16 vidual—

17 “(A) is enrolled in a health benefits plan  
18 under chapter 89 of title 5, United States Code,

19 “(B) is entitled to receive benefits under  
20 chapter 55 of title 10, United States Code,

21 “(C) is entitled to receive benefits under  
22 chapter 17 of title 38, United States Code,

23 “(D) is enrolled in a group health plan  
24 (within the meaning of section 5000(b)(1))  
25 which is subsidized by the employer, or

1           “(E) is a member of a health care sharing  
2           ministry.

3           “(3) HEALTH CARE SHARING MINISTRY.—For  
4           purposes of this subsection, the term ‘health care  
5           sharing ministry’ means an organization—

6           “(A) which is described in section  
7           501(c)(3) and is exempt from taxation under  
8           section 501(a),

9           “(B) members of which share a common  
10          set of ethical or religious beliefs and share med-  
11          ical expenses among members in accordance  
12          with those beliefs and without regard to the  
13          State in which a member resides or is em-  
14          ployed,

15          “(C) members of which retain membership  
16          even after they develop a medical condition,

17          “(D) which (or a predecessor of which) has  
18          been in existence at all times since December  
19          31, 1999, and medical expenses of its members  
20          have been shared continuously and without  
21          interruption since at least December 31, 1999,  
22          and

23          “(E) which conducts an annual audit  
24          which is performed by an independent certified  
25          public accounting firm in accordance with gen-

1           erally accepted accounting principles and which  
2           is made available to the public upon request.

3           “(g) SPECIAL RULES.—

4           “(1) CREDIT IN EXCESS OF PREMIUMS ONLY  
5           PAYABLE TO A HEALTH SAVINGS ACCOUNT.—

6           “(A) IN GENERAL.—If the credit allowed  
7           under subsection (a) (determined without re-  
8           gard to clause (ii)) for any taxable year exceeds  
9           the amount of premiums paid by the taxpayer  
10          for coverage of the taxpayer and the taxpayer’s  
11          qualifying family members under qualified  
12          health insurance for eligible coverage months  
13          beginning in the taxable year—

14                 “(i) at the request of the taxpayer,  
15                 the Secretary shall pay the amount of such  
16                 excess to one or more health savings ac-  
17                 counts of the taxpayer or of any qualifying  
18                 family member of the taxpayer, and

19                 “(ii) the credit allowed under sub-  
20                 section (a) for such taxable year shall not  
21                 exceed the amount of such premiums.

22           “(B) MEDICAL AND HEALTH SAVINGS AC-  
23           COUNTS.—Amounts distributed from an Archer  
24           MSA (as defined in section 220(d)) or from a  
25           health savings account (as defined in section

1           223(d)) shall not be taken into account as pre-  
2           miums paid under subparagraph (A).

3           “(C) INSURANCE WHICH COVERS OTHER  
4           INDIVIDUALS.—For purposes of this paragraph,  
5           rules similar to the rules of section 213(d)(6)  
6           shall apply with respect to any contract for  
7           qualified health insurance under which amounts  
8           are payable for coverage of an individual other  
9           than the taxpayer and qualifying family mem-  
10          bers.

11          “(D) CONTRIBUTIONS TREATED AS ROLL-  
12          OVERS, ETC.—

13           “(i) IN GENERAL.—Any amount paid  
14           the Secretary to a health savings account  
15           under this paragraph shall be treated for  
16           purposes of this title in the same manner  
17           as a rollover contribution described in sec-  
18           tion 223(f)(5).

19           “(ii) COORDINATION WITH LIMITA-  
20           TION ON ROLLOVERS.—Any amount de-  
21           scribed in clause (i) shall not be taken into  
22           account in applying section 223(f)(5)(B)  
23           with respect to any other amount and the  
24           limitation of section 223(f)(5)(B) shall not

1 apply with respect to the application of  
2 clause (i).

3 “(iii) ESTABLISHMENT OF HSAS.—  
4 Nothing in any provision of law shall be  
5 construed—

6 “(I) to prevent an individual  
7 from establishing a health savings ac-  
8 count (as defined in section 223(d))  
9 merely because such individual is not  
10 an eligible individual (as defined in  
11 section 223(e)), or

12 “(II) to prevent such an account  
13 from being treated as a health savings  
14 account merely because all or a sub-  
15 stantial portion of the contributions to  
16 such account are described in this  
17 paragraph.

18 “(2) COORDINATION WITH ADVANCE PAYMENTS  
19 OF CREDIT.—With respect to any taxable year—

20 “(A) the amount which would (but for this  
21 subsection) be allowed as a credit to the tax-  
22 payer under subsection (a) shall be reduced  
23 (but not below zero) by the aggregate amount  
24 paid on behalf of such taxpayer under section

1           7529 for months beginning in such taxable  
2           year, and

3           “(B) the tax imposed by section 1 for such  
4           taxable year shall be increased by the excess (if  
5           any) of—

6           “(i) the aggregate amount paid on be-  
7           half of such taxpayer under section 7529  
8           for months beginning in such taxable year,  
9           over

10          “(ii) the amount which would (but for  
11          this subsection) be allowed as a credit to  
12          the taxpayer under subsection (a).

13          “(3) COORDINATION WITH OTHER PROVI-  
14          SIONS.—For purposes of any deduction allowed  
15          under section 162(l), 213, or 224, and any credit al-  
16          lowed under section 35, any health insurance pre-  
17          miums which would (but for this paragraph) be  
18          taken into account shall be reduced (but not below  
19          zero) by the amount of the credit allowed under this  
20          section (determined without regard to paragraphs  
21          (1) and (2) of this subsection).

22          “(4) DENIAL OF CREDIT TO DEPENDENTS AND  
23          NONPERMANENT RESIDENT ALIEN INDIVIDUALS.—  
24          No credit shall be allowed under this section to any  
25          individual who is—



1 mined as of any time during any calendar year, shall not  
2 exceed the monthly credit amounts determined with re-  
3 spect to such taxpayer under section 36C for months dur-  
4 ing such calendar year which have ended as of such time.

5       “(c) APPLICATION OF RULE THAT CREDITS IN EX-  
6 CESS OF PREMIUMS ONLY PAYABLE TO A HEALTH SAV-  
7 INGS ACCOUNT.—Under rules similar to the rules of sec-  
8 tion 36C(g)(1), any amount otherwise payable on behalf  
9 of the taxpayer under subsection (a) with respect to any  
10 eligible coverage month which is in excess of the amount  
11 of premiums paid by the taxpayer for coverage of the tax-  
12 payer and the taxpayer’s qualifying family members under  
13 qualified health insurance for such month shall be payable  
14 only to one or more health savings accounts of the tax-  
15 payer or of any qualifying family member of the taxpayer.

16       “(d) CERTIFICATION PROCESS AND PROOF OF COV-  
17 ERAGE.—The Secretary shall establish a process under  
18 which individuals are certified as eligible for payment  
19 under this section. Such process shall include an initial  
20 application by the taxpayer to determine eligibility and  
21 thereafter continued eligibility shall be determined, to the  
22 maximum extent feasible, by the Secretary on the basis  
23 of information provided under section 6050X.

24       “(e) DEFINITIONS.—For purposes of this section,  
25 terms used in this section which are also used in section

1 36C shall have the same meaning as when used in section  
2 36C.”.

3 (2) INFORMATION REPORTING.—

4 (A) IN GENERAL.—Subpart B of part III  
5 of subchapter A of chapter 61 of such Code (re-  
6 lating to information concerning transactions  
7 with other persons) is amended by adding at  
8 the end the following new section:

9 **“SEC. 6050X. RETURNS RELATING TO CREDIT FOR HEALTH**  
10 **INSURANCE COVERAGE.**

11 “(a) REQUIREMENT OF REPORTING.—Every person  
12 who provides qualified health insurance for any month of  
13 any calendar year with respect to any individual shall, at  
14 such time as the Secretary may prescribe, make the return  
15 described in subsection (b) with respect to each such indi-  
16 vidual. With respect to any individual with respect to  
17 whom payments under section 7529 are made by the Sec-  
18 retary, the Secretary may require that reporting under  
19 subsection (b) be made on a monthly basis.

20 “(b) FORM AND MANNER OF RETURNS.—A return  
21 is described in this subsection if such return—

22 “(1) is in such form as the Secretary may pre-  
23 scribe, and

24 “(2) contains, with respect to each policy of  
25 qualified health insurance—

1           “(A) the name, address, and TIN of each  
2 individual covered under such policy,

3           “(B) the premiums paid with respect to  
4 such policy, and

5           “(C) such other information as the Sec-  
6 retary may prescribe.

7           “(c) STATEMENTS TO BE FURNISHED TO INDIVID-  
8 UALS WITH RESPECT TO WHOM INFORMATION IS RE-  
9 QUIRED.—Every person required to make a return under  
10 subsection (a) shall furnish to each individual whose name  
11 is required to be set forth in such return a written state-  
12 ment showing—

13           “(1) the name and address of the person re-  
14 quired to make such return and the phone number  
15 of the information contact for such person, and

16           “(2) the information required to be shown on  
17 the return with respect to such individual.

18 The written statement required under the preceding sen-  
19 tence shall be furnished on or before January 31 of the  
20 year following the calendar year to which such statement  
21 relates.

22           “(d) DEFINITIONS.—For purposes of this section,  
23 terms used in this section which are also used in section  
24 36C shall have the same meaning as when used in section  
25 36C.”.

1 (B) ASSESSABLE PENALTIES.—

2 (i) Subparagraph (B) of section  
3 6724(d)(1) of such Code is amended by  
4 striking “or” at the end of clause (xxiv),  
5 by striking “and” at the end of clause  
6 (xxv) and inserting “or”, and by inserting  
7 after clause (xxv) the following new clause:

8 “(xxvi) section 6050X (relating to re-  
9 turns relating to credit for health insur-  
10 ance coverage), and”.

11 (ii) Paragraph (2) of section 6724(d)  
12 of such Code is amended by striking “or”  
13 at the end of subparagraph (GG), by strik-  
14 ing the period at the end of subparagraph  
15 (HH) and inserting “, or”, and by adding  
16 after subparagraph (HH) the following  
17 new subparagraph:

18 “(II) section 6050X (relating to returns  
19 relating to credit for health insurance cov-  
20 erage).”.

21 (3) DISCLOSURE OF RETURN INFORMATION  
22 FOR PURPOSES OF ADVANCE PAYMENT OF CREDIT  
23 AS PREMIUMS FOR QUALIFIED HEALTH INSUR-  
24 ANCE.—

1 (A) IN GENERAL.—Subsection (l) of sec-  
2 tion 6103 of such Code is amended by adding  
3 at the end the following new paragraph:

4 “(23) DISCLOSURE OF RETURN INFORMATION  
5 RELATED TO PAYMENTS OF THE HEALTH INSUR-  
6 ANCE COVERAGE CREDIT.—The Secretary may, on  
7 behalf of taxpayers eligible for the credit under sec-  
8 tion 36C, disclose to a provider of qualified health  
9 insurance (as defined in section 36(e)) or a trustee  
10 of a health savings account (and persons acting on  
11 behalf of such provider or such trustee), return in-  
12 formation with respect to any such taxpayer only to  
13 the extent necessary (as prescribed by regulations  
14 issued by the Secretary) to carry out sections  
15 36C(g)(1) (relating to credit in excess of premiums  
16 only payable to a health savings account) and 7529  
17 (relating to advance payment of credit for health in-  
18 surance coverage).”.

19 (B) CONFIDENTIALITY OF INFORMA-  
20 TION.—Paragraph (3) of section 6103(a) of  
21 such Code is amended by striking “or (21)”  
22 and inserting “(21), or (22)”.

23 (C) UNAUTHORIZED DISCLOSURE.—Para-  
24 graph (2) of section 7213(a) of such Code is

1 amended by striking “or (21)” and inserting  
2 “(21), or (22)”.

3 (4) EFFECTIVE DATE.—Subject to section 1(e),  
4 the amendments made by this section shall take ef-  
5 fect on the date of the enactment of this Act.

6 (c) CONFORMING AMENDMENTS.—

7 (1) Paragraph (2) of section 1324(b) of title  
8 31, United States Code is amended by inserting  
9 “36C,” after “36B,”.

10 (2) The table of sections for subpart C of part  
11 IV of subchapter A of chapter 1 of the Internal Rev-  
12 enue Code of 1986 is amended by inserting after the  
13 item relating to section 36B the following new item:

“Sec. 36C. Health insurance coverage.”.

14 (4) The table of sections for subpart B of part  
15 III of subchapter A of chapter 61 of such Code is  
16 amended by adding at the end the following new  
17 item:

“Sec. 6050X. Returns relating to credit for health insurance coverage.”.

18 (5) The table of sections for chapter 77 of such  
19 Code is amended by adding at the end the following  
20 new item:

“Sec. 7529. Advance payment of credit for health insurance coverage.”.

21 (d) EFFECTIVE DATE.—Subject to section 1(e), the  
22 amendments made by this section shall apply with respect

1 to coverage months beginning on or after the *King v.*  
2 *Burwell* effective date.

3 **SEC. 3. RESTORING TO STATES THE FREEDOM AND FLEXI-**  
4 **BILITY TO REGULATE HEALTH INSURANCE**  
5 **MARKETS.**

6 (a) **ELIMINATION OF PPACA RESTRICTIONS ON THE**  
7 **INSURANCE MARKET.**—Any provision of title I of the Pa-  
8 tient Protection and Affordable Care Act (Public Law  
9 111–148) or of the Health Care and Education Reconcili-  
10 ation Act of 2010 (Public Law 111–152) amending title  
11 XXVII of the Public Health Service Act (42 U.S.C. 300gg  
12 et seq.), or amending the Internal Revenue Code of 1986  
13 or the Employee Retirement Income Security Act of 1974  
14 in order to incorporate or apply such an amendment to  
15 such title XXVII, is repealed and the provisions of law  
16 amended by such provisions of title I of the Patient Pro-  
17 tection and Affordable Care Act and the Health Care and  
18 Education Reconciliation Act of 2010 are restored or re-  
19 vived as if such title and Act had not been enacted.

20 (b) **HSAS AND FSAS.**—Any provision of, or amend-  
21 ment made by, the Patient Protection and Affordable Care  
22 Act (Public Law 111–148) or the Health Care and Edu-  
23 cation Reconciliation Act of 2010 (Public Law 111–152)  
24 applying a requirement or restriction on a health savings  
25 account (within the meaning of section 223(d) of the In-

1 ternal Revenue Code of 1986) or a health flexible spending  
2 arrangement (within the meaning of section 106(c) of the  
3 Internal Revenue Code of 1986) is repealed and the provi-  
4 sions of law amended by such provisions of the Patient  
5 Protection and Affordable Care Act and the Health Care  
6 and Education Reconciliation Act of 2010 are restored or  
7 revived as if such Acts had not been enacted.

8 (c) EXPANDED HEALTH PLAN SELECTION.—

9 (1) IN GENERAL.—Section 1301(a)(1) of the  
10 Patient Protection and Affordable Care Act (42  
11 U.S.C. 18021(a)(1)) is amended by striking “a  
12 health plan that” and all that follows through the  
13 period at the end and inserting “any health plan (as  
14 defined in subsection (b)).”.

15 (2) DIRECT PRIMARY CARE MEDICAL HOME  
16 PLANS.—Section 1301(a)(3) of such Act (42 U.S.C.  
17 18021(a)(3)) is amended by striking “medical home  
18 plan that meets criteria” and all that follows  
19 through the period at the end and inserting “medical  
20 home plan.”.

21 (3) STAND-ALONE DENTAL BENEFITS.—Section  
22 1311(d)(2)(B)(ii) of such Act (42 U.S.C.  
23 18031(d)(2)(B)(ii)) is amended by striking “health  
24 plan) if the plan” and all that follows through the  
25 period at the end and inserting “health plan).”.

1           (4) CONFORMING AMENDMENTS.—The fol-  
2           lowing provisions of the Patient Protection and Af-  
3           fordable Care Act (Public Law 111–148) shall have  
4           no force or effect after the date of the enactment of  
5           this Act:

6                   (A) Section 1301(b)(1)(B) of such Act (42  
7           U.S.C. 18021(b)(1)(B)).

8                   (B) Paragraphs (1), (2), and (6) of section  
9           1311(c) of such Act (42 U.S.C. 18031(c)).

10                  (C) Section 1311(d)(4)(A) of such Act (42  
11           U.S.C. 18031(d)(4)(A)).

12                  (D) Section 1311(e) of such Act (42  
13           U.S.C. 18031(e)).

14                  (E) Section 1311(j) of such Act (42 U.S.C.  
15           18031(j)).

16                  (F) Subparagraphs (B) and (D) of section  
17           1321(a)(1) of such Act (42 U.S.C.  
18           18041(a)(1)).

19   **SEC. 4. POOL REFORM FOR INDIVIDUAL MEMBERSHIP EX-**  
20                   **PANSION.**

21           The Public Health Service Act is further amended by  
22   adding at the end the following:

1 **“TITLE XXXIV—POOL REFORM**  
2 **FOR INDIVIDUAL MEMBER-**  
3 **SHIP EXPANSION**

4 **“SEC. 3400. PURPOSE.**

5 “The purpose of this title is to provide, through the  
6 establishment of individual health pools (or IHPs), for the  
7 reform of, and expansion of enrollment in, health insur-  
8 ance coverage for individuals and small employers.

9 **“SEC. 3401. DEFINITION OF INDIVIDUAL HEALTH POOL**  
10 **(IHP).**

11 “(a) IN GENERAL.—For purposes of this title, the  
12 terms ‘individual health pool’ and ‘IHP’ mean a legal non-  
13 profit entity that meets the following requirements:

14 “(1) ORGANIZATION.—The IHP—

15 “(A) has been formed and maintained in  
16 good faith for a purpose that includes the for-  
17 mation of a risk pool in order to offer health in-  
18 surance coverage to its members;

19 “(B) does not condition membership in the  
20 IHP on any health status-related factor relating  
21 to an individual (including an employee of an  
22 employer or a dependent of an employee);

23 “(C) does not make health insurance cov-  
24 erage offered through the IHP available other  
25 than in connection with a member of the IHP;

1           “(D) is not a health insurance issuer; and

2           “(E) does not receive any consideration di-  
3           rectly or indirectly from any health insurance  
4           issuer in connection with the enrollment of any  
5           individuals, or employees of employers, in any  
6           health insurance coverage, except in conjunction  
7           with services offered through the IHP.

8           “(2) OFFERING HEALTH BENEFITS COV-  
9           ERAGE.—

10           “(A) DIFFERENT GROUPS.—The IHP, in  
11           conjunction with those health insurance issuers  
12           that offer health benefits coverage through the  
13           IHP, makes available health benefits coverage  
14           in the manner described in subsection (b) to all  
15           members of the IHP and the dependents of  
16           such members (and, in the case of small em-  
17           ployers, employees and their dependents) in the  
18           manner described in subsection (c)(2) at rates  
19           that are established by the health insurance  
20           issuer on a policy or product specific basis and  
21           that may vary for individuals covered through  
22           an IHP.

23           “(B) NONDISCRIMINATION IN COVERAGE  
24           OFFERED.—

1                   “(i) IN GENERAL.—Subject to clause  
2                   (ii), the IHP may not offer health benefits  
3                   coverage to a member of an IHP unless  
4                   the same coverage is offered to all such  
5                   members of the IHP.

6                   “(ii) CONSTRUCTION.—Nothing in  
7                   this title shall be construed as requiring or  
8                   permitting a health insurance issuer to  
9                   provide coverage outside the service area of  
10                  the issuer, as approved under State law, or  
11                  preventing a health insurance issuer from  
12                  underwriting or from excluding or limiting  
13                  the coverage on any individual, subject to  
14                  the requirement of section 2741 (relating  
15                  to guaranteed availability of individual  
16                  health insurance coverage to certain indi-  
17                  viduals with prior group coverage).

18                  “(C) NO ASSUMPTION OF INSURANCE RISK  
19                  BY IHP.—The IHP provides health benefits cov-  
20                  erage only through contracts with health insur-  
21                  ance issuers and does not assume insurance  
22                  risk with respect to such coverage.

23                  “(3) GEOGRAPHIC AREAS.—Nothing in this title  
24                  shall be construed as preventing the establishment  
25                  and operation of more than one IHP in a geographic

1 area or as limiting the number of IHPs that may  
2 operate in any area.

3 “(4) PROVISION OF ADMINISTRATIVE SERVICES  
4 TO PURCHASERS.—The IHP may provide adminis-  
5 trative services for members. Such services may in-  
6 clude accounting, billing, and enrollment informa-  
7 tion.

8 “(b) HEALTH BENEFITS COVERAGE REQUIRE-  
9 MENTS.—

10 “(1) COMPLIANCE WITH CONSUMER PROTEC-  
11 TION REQUIREMENTS.—Except as provided in sec-  
12 tion 3402, any health benefits coverage offered  
13 through an IHP—

14 “(A) shall be issued by a health insurance  
15 issuer that meets all applicable State standards  
16 relating to consumer protection;

17 “(B) shall be approved or otherwise per-  
18 mitted to be offered under State law; and

19 “(C) may not impose any exclusion of a  
20 specific disease from such coverage.

21 “(2) WELLNESS BONUSES FOR HEALTH PRO-  
22 MOTION.—Nothing in this title shall be construed as  
23 precluding a health insurance issuer offering health  
24 benefits coverage through an IHP from establishing  
25 premium discounts or rebates for members or from

1       modifying otherwise applicable copayments or  
2       deductibles in return for adherence to programs of  
3       health promotion and disease prevention so long as  
4       such programs are agreed to in advance by the IHP  
5       and comply with all other provisions of this title and  
6       do not discriminate among similarly situated mem-  
7       bers.

8       “(c) MEMBERS; HEALTH INSURANCE ISSUERS.—

9               “(1) MEMBERS.—

10                       “(A) IN GENERAL.—Under rules estab-  
11                       lished to carry out this title, with respect to an  
12                       individual or small employer who is a member  
13                       of an IHP, the individual may enroll for health  
14                       benefits coverage (including coverage for de-  
15                       pendents of such individual) or employer may  
16                       enroll employees for health benefits coverage  
17                       (including coverage for dependents of such em-  
18                       ployees) offered by a health insurance issuer  
19                       through the IHP.

20                       “(B) RULES FOR ENROLLMENT.—Nothing  
21                       in this paragraph shall preclude an IHP from  
22                       establishing rules of enrollment and reenroll-  
23                       ment of members. Such rules shall be applied  
24                       consistently to all members within the IHP and

1           shall not be based in any manner on health sta-  
2           tus-related factors.

3           “(2) HEALTH INSURANCE ISSUERS.—The con-  
4           tract between an IHP and a health insurance issuer  
5           shall provide, with respect to a member enrolled with  
6           health benefits coverage offered by the issuer  
7           through the IHP, for the payment to the issuer of  
8           the premiums (if any) collected by the IHP for  
9           health insurance coverage offered by the issuer.

10   **“SEC. 3402. APPLICATION OF CERTAIN LAWS AND REQUIRE-**  
11                           **MENTS.**

12           “(a) PREEMPTION OF STATE LAWS RESTRICTING  
13   FORMATION OF IHPs.—Any State law or regulation relat-  
14   ing to the composition or organization of an IHP is pre-  
15   empted to the extent the law or regulation is inconsistent  
16   with the provisions of this title.

17           “(b) PREEMPTION OF STATE REQUIREMENTS RE-  
18   LATING TO HEALTH BENEFIT COVERAGE.—

19           “(1) BENEFIT REQUIREMENTS.—

20                   “(A) IN GENERAL.—Subject to subpara-  
21                   graph (B), State laws are superseded, and shall  
22                   not apply to health benefits coverage made  
23                   available through an IHP, insofar as such laws  
24                   impose benefit requirements for such coverage,  
25                   including (but not limited to) requirements re-

1           lating to coverage of specific providers, specific  
2           services or conditions, or the amount, duration,  
3           or scope of benefits.

4           “(B) EXCEPTION FOR FEDERALLY IM-  
5           POSED REQUIREMENTS AND FOR REQUIRE-  
6           MENTS PROHIBITING DISEASE-SPECIFIC EXCLU-  
7           SIONS.—Subparagraph (A) shall not apply to a  
8           requirement to the extent the requirement—

9                   “(i) implements title XXVII or other  
10                  Federal law; or

11                   “(ii) prohibits imposition of an exclu-  
12                  sion of a specific disease from health bene-  
13                  fits coverage.

14           “(2) OTHER REQUIREMENTS PREVENTING OF-  
15           FERING OF COVERAGE THROUGH AN IHP.—State  
16           laws are superseded, and shall not apply to health  
17           benefits coverage made available through an IHP,  
18           insofar as such laws impose any other requirements  
19           (including limitations on compensation arrange-  
20           ments) that, directly or indirectly, preclude (or have  
21           the effect of precluding) the offering of such cov-  
22           erage through an IHP, if the IHP meets the re-  
23           quirements of this title.

24           “(c) PREEMPTION OF STATE PREMIUM RATING RE-  
25           QUIREMENTS.—State laws are superseded, and shall not

1 apply to the premiums imposed for health benefits cov-  
2 erage made available through an IHP, insofar as such  
3 laws impose restrictions on the variation of premiums  
4 among such coverage offered to members of the IHP.

5 **“SEC. 3403. DEFINITIONS.**

6 “For purposes of this title:

7 “(1) **DEPENDENT.**—The term ‘dependent’, as  
8 applied to health insurance coverage offered by a  
9 health insurance issuer licensed (or otherwise regu-  
10 lated) in a State, shall have the meaning applied to  
11 such term with respect to such coverage under the  
12 laws of the State relating to such coverage and such  
13 an issuer. Such term may include the spouse and  
14 children of the individual involved.

15 “(2) **HEALTH BENEFITS COVERAGE.**—The term  
16 ‘health benefits coverage’ has the meaning given the  
17 term health insurance coverage in section  
18 2791(b)(1), and does not include excepted benefits  
19 (as defined in section 2791(c)).

20 “(3) **HEALTH INSURANCE ISSUER.**—The term  
21 ‘health insurance issuer’ has the meaning given such  
22 term in section 2791(b)(2).

23 “(4) **HEALTH STATUS-RELATED FACTOR.**—The  
24 term ‘health status-related factor’ has the meaning  
25 given such term in section 2791(d)(9).

1           “(5) MEMBER.—The term ‘member’ means,  
2           with respect to an IHP, an individual or small em-  
3           ployer who is a member of the legal entity described  
4           in section 3401(a)(1) to which the IHP is offering  
5           coverage.

6           “(6) SMALL EMPLOYER.—The term ‘small em-  
7           ployer’ has the meaning given such term in section  
8           712(c)(1)(B) of the Employee Retirement and In-  
9           come Security Act of 1974.”.

10 **SEC. 5. REQUIREMENTS FOR INDIVIDUAL HEALTH INSUR-**  
11 **ANCE.**

12           (a) IN GENERAL.—Section 2741 of the Public Health  
13           Service Act (42 U.S.C. 300gg-41), as restored and revived  
14           by section 3 of this Act, is amended—

15           (1) in subsection (a)—

16                   (A) in the heading, by striking “TO CER-  
17                   TAIN INDIVIDUALS WITH PRIOR GROUP COV-  
18                   ERAGE”;

19                   (B) in paragraph (1), by striking “and sec-  
20                   tion 2744”;

21                   (C) in paragraph (1)(B), by inserting “un-  
22                   less such exclusion complies with paragraph  
23                   (2)” before the period; and

24                   (D) by striking paragraph (2) and insert-  
25                   ing the following new paragraphs:

1           “(2) LIMITATION ON PREEXISTING CONDITION  
2           EXCLUSION PERIOD.—

3           “(A) LIMITATION.—A health insurance  
4           issuer offering health insurance coverage in the  
5           individual market may not, with respect to an  
6           enrollee in such coverage, impose any pre-  
7           existing condition exclusion if such enrollee has  
8           at least 18 months of continuous creditable cov-  
9           erage (as defined in section 2701(c)(1)) imme-  
10          diately preceding the enrollment date.

11          “(B) IMPOSITION OF EXCLUSION.—Not-  
12          withstanding paragraph (1)(B), a health insur-  
13          ance issuer offering health insurance coverage  
14          in the individual market may, with respect to  
15          an enrollee in such coverage who is not de-  
16          scribed in subparagraph (A), impose a pre-  
17          existing condition exclusion only if—

18                  “(i) such exclusion relates to a condi-  
19                  tion (whether physical or mental), regard-  
20                  less of the cause of the condition, for which  
21                  medical advice, diagnosis, care, or treat-  
22                  ment was recommended or received within  
23                  the 6-month period ending on the enroll-  
24                  ment date;

1           “(ii) such exclusion extends for a pe-  
2           riod of not more than 18 months after the  
3           enrollment date; and

4           “(iii) the period of any such pre-  
5           existing condition exclusion is reduced by  
6           the aggregate of the periods of creditable  
7           coverage (if any, as defined in section  
8           2701(c)(1)) applicable to the enrollee as of  
9           the enrollment date.

10          “(C) PREMIUM SURCHARGE.—Notwith-  
11          standing paragraph (6), with respect to an en-  
12          rollee described in subparagraph (B), a health  
13          insurance issuer may charge a premium for the  
14          coverage involved that does not exceed 150 per-  
15          cent of the applicable standard rate, for not to  
16          exceed 24 months (or 36 months if the health  
17          insurance issuer does not impose any pre-  
18          existing condition exclusion with respect to such  
19          enrollee), reduced by the aggregate of the peri-  
20          ods of creditable coverage (if any, as defined in  
21          section 2701(c)(1)) applicable to the enrollee as  
22          of the enrollment date. For purposes of this  
23          subsection, the term ‘applicable standard rate’  
24          means the standard premium rate that the  
25          issuer charges for the coverage involved with re-

1           spect to an individual described in subpara-  
2           graph (A) with the same rating characteristics  
3           or rating factors as the enrollee described in  
4           subparagraph (B), provided that any variations  
5           in standard premium rates are based on the  
6           uniform application of rating characteristics or  
7           rating factors that are permitted by State law  
8           and are not otherwise prohibited by paragraph  
9           (6).

10           “(3) EXCEPTIONS.—Notwithstanding para-  
11           graph (2), and subject to subparagraph (D), a  
12           health insurance issuer offering health insurance  
13           coverage in the individual market, may not impose  
14           any of the following preexisting condition exclusion:

15                   “(A) EXCLUSION NOT APPLICABLE TO  
16                   CERTAIN NEWBORNS.—In the case of an indi-  
17                   vidual who, as of the last day of the 30-day pe-  
18                   riod beginning with the date of birth, is a de-  
19                   pendent of an enrollee in such coverage.

20                   “(B) EXCLUSION NOT APPLICABLE TO  
21                   CERTAIN ADOPTED CHILDREN.—In the case of  
22                   a child who is adopted or placed for adoption  
23                   before attaining 18 years of age and who, as of  
24                   the last day of the 30-day period beginning on  
25                   the date of the adoption or placement for adop-

1           tion, is a dependent of an enrollee in such cov-  
2           erage. The previous sentence shall not apply to  
3           coverage before the date of such adoption or  
4           placement for adoption.

5           “(C) EXCLUSION NOT APPLICABLE TO  
6           PREGNANCY.—Relating to pregnancy as a pre-  
7           existing condition.

8           “(D) LOSS IF BREAK IN COVERAGE.—Sub-  
9           paragraphs (A) and (B) shall no longer apply  
10          to an individual after the end of the first 63-  
11          day period during all of which the individual  
12          was not covered under any creditable coverage.

13          “(4) OPEN ENROLLMENT PERIODS.—A health  
14          insurance issuer offering health insurance coverage  
15          in the individual market may limit the applicability  
16          of the provisions of paragraph (1) to scheduled open  
17          enrollment periods, provided that—

18                 “(A) any such open enrollment period shall  
19                 not be less than 30 days;

20                 “(B) any period between scheduled open  
21                 enrollment periods shall not exceed 24 months;  
22                 and

23                 “(C) such limitation shall not apply to any  
24                 individual who qualifies for a special enrollment  
25                 period under paragraph (5).

1           “(5) SPECIAL ENROLLMENT PERIODS.—Subject  
2           to subparagraphs (E) and (F), a health insurance  
3           issuer offering health insurance coverage in the indi-  
4           vidual market shall permit an individual who is an  
5           eligible individual or a dependent to enroll in cov-  
6           erage during a special enrollment period if the indi-  
7           vidual experiences any of the following qualifying  
8           events:

9                   “(A) FOR DEPENDENT BENEFICIARIES.—  
10           The individual becomes, by reason of marriage,  
11           birth, adoption or placement for adoption, a de-  
12           pendent of an individual enrolled in a plan of-  
13           fered by the health insurance issuer and such  
14           individual otherwise qualifies, under the terms  
15           of the plan, as eligible for coverage as a depend-  
16           ent of such enrollee.

17                   “(B) LOSS OF GROUP COVERAGE.—The in-  
18           dividual loses coverage under a group health  
19           plan as a result of—

20                   “(i) loss of eligibility for the coverage  
21           (including as a result of legal separation,  
22           divorce, death, attaining an age at which  
23           eligibility terminates, termination of em-  
24           ployment, or reduction in the number of  
25           hours of employment); or

1                   “(ii) termination of the coverage by  
2                   the plan sponsor.

3                   “(C) LOSS OF INDIVIDUAL COVERAGE.—  
4                   The individual loses individual market coverage  
5                   as a result of—

6                   “(i) discontinuation of a plan as a re-  
7                   sult of a health insurance issuer ceasing to  
8                   offer coverage in the individual market in  
9                   accordance with section 2742(c)(2) (42  
10                  U.S.C. 300gg-42(c)(2)) of this title;

11                  “(ii) expiration of COBRA, or other,  
12                  continuation coverage;

13                  “(iii) ceasing to qualify, under the  
14                  terms of the coverage, as a dependent (in-  
15                  cluding as a result of legal separation, di-  
16                  vorce, death, or attaining an age at which  
17                  eligibility terminates); and

18                  “(iv) permanently moving outside the  
19                  State in which the coverage was issued, or  
20                  in the case of a network plan, outside the  
21                  plan’s service area.

22                  “(D) LOSS OF ELIGIBILITY FOR A GOV-  
23                  ERNMENT COVERAGE PROGRAM.—The indi-  
24                  vidual loses coverage by ceasing to be eligible  
25                  for coverage under any of the following:

1           “(i) Part A or part B of title XVIII  
2 of the Social Security Act (42 U.S.C.  
3 1395c et seq., 1395j et seq.).

4           “(ii) Title XIX of the Social Security  
5 Act (42 U.S.C. 1396 et seq.), other than  
6 coverage consisting solely of benefits under  
7 section 1928 (42 U.S.C. 1396s).

8           “(iii) Title XXI of the Social Security  
9 Act (42 U.S.C. 1397aa et seq.).

10          “(iv) Chapter 55 of title 10.

11          “(v) Chapter 89 of title 5.

12          “(vi) A State health benefits risk pool.

13          “(E) LOSS OF COVERAGE DESCRIBED.—  
14 For purposes of this paragraph, loss of cov-  
15 erage shall not include any of the following:

16           “(i) Voluntary termination of coverage  
17 by an individual, except if such termination  
18 is the result of circumstances described in  
19 subparagraph (C)(iv).

20           “(ii) Termination of coverage by the  
21 issuer or the plan sponsor of the coverage  
22 for any reason described in paragraphs (1)  
23 or (2) of section 2742(b) (300gg-42(b)) of  
24 this title.

1                   “(iii) Loss of any coverage that con-  
2                   sists solely of coverage of excepted benefits  
3                   (as defined in section 300gg–91(c) of this  
4                   title).

5                   “(F) LIMITATION ON SPECIAL ENROLL-  
6                   MENT PERIOD.—Any special enrollment period  
7                   shall not be less than 60 days and shall begin  
8                   on the date of the qualifying event.

9                   “(6) STANDARD PREMIUM RATES.—With re-  
10                  spect to the premium rate charged by a health insur-  
11                  ance issuer for health insurance coverage offered in  
12                  the individual market, such rate, with respect to the  
13                  particular plan or coverage involved, shall not vary  
14                  based on any of the following health status-related  
15                  factors in relation to an eligible individual or de-  
16                  pendent:

17                         “(A) Health status.

18                         “(B) Medical condition (including both  
19                         physical and mental illnesses).

20                         “(C) Claims experience.

21                         “(D) Receipt of health care.

22                         “(E) Medical history.

23                         “(F) Genetic information.

1           “(G) Evidence of insurability (including  
2           conditions arising out of acts of domestic vio-  
3           lence).

4           “(H) Disability.”;

5           (2) by amending subsection (b) to read as fol-  
6           lows:

7           “(b) DEFINITIONS.—For purposes of this section:

8           “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible  
9           individual’ means an individual who is eligible under  
10          applicable State law to purchase individual health in-  
11          surance coverage in the State.

12          “(2) DEPENDENT.—The term ‘dependent’  
13          means an individual who, under the terms of the  
14          coverage and applicable State law, qualifies to enroll  
15          in such coverage as a dependent of an individual de-  
16          scribed in paragraph (1).”; and

17          (3) by striking subsection (c) and redesignating  
18          subsection (d) and the first subsection (e) as sub-  
19          sections (c) and (d), respectively.

20          (b) CONFORMING AMENDMENT.—Section 2744 of the  
21          Public Health Service Act (42 U.S.C. 300gg–44), as re-  
22          stored and revived by section 3 of this Act, is repealed.

23          (c) EFFECTIVE DATE.—Subject to section 1(c), the  
24          amendments made by this section shall apply with respect

- 1 to health insurance coverage offered for plan years begin-
- 2 ning on or after the *King v. Burwell* effective date.