

112TH CONGRESS
1ST SESSION

H. R. 3000

To provide for incentives to encourage health insurance coverage, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 21, 2011

Mr. PRICE of Georgia (for himself, Mr. BURTON of Indiana, Mr. WILSON of South Carolina, Mr. SESSIONS, and Mr. FLEMING) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and the Workforce, Ways and Means, the Judiciary, Natural Resources, Rules, House Administration, Appropriations, Oversight and Government Reform, and the Budget, 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 provide for incentives to encourage health insurance coverage, and for other purposes.

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

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Empowering Patients First Act”.

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

- Sec. 1. Short title; table of contents.
 Sec. 2. Repeal of PPACA and health care-related HCERA provisions.

TITLE I—TAX INCENTIVES FOR MAINTAINING HEALTH INSURANCE COVERAGE

- Sec. 101. Refundable tax credit for health insurance costs of low-income individuals.
 Sec. 102. Advance payment of credit as premium payment for qualified health insurance.
 Sec. 103. Election of tax credit instead of alternative government or group plan benefits.
 Sec. 104. Deduction for qualified health insurance costs of individuals.
 Sec. 105. Limitation on abortion funding.
 Sec. 106. No government discrimination against certain health care entities.
 Sec. 107. Equal employer contribution rule to promote choice.
 Sec. 108. Limitations on State restrictions on employer auto-enrollment.
 Sec. 109. Credit for small employers adopting auto-enrollment and defined contribution options.
 Sec. 110. HSA modifications and clarifications.

TITLE II—HEALTH INSURANCE POOLING MECHANISMS FOR INDIVIDUALS

Subtitle A—Safety Net for Individuals With Pre-Existing Conditions

- Sec. 201. Requiring operation of high-risk pool or other mechanism as condition for availability of tax credit.

Subtitle B—Federal Block Grants for State Insurance Expenditures

- Sec. 211. Federal block grants for State insurance expenditures.

Subtitle C—Health Care Access and Availability

- Sec. 221. Expansion of access and choice through individual membership associations (IMAs).

Subtitle D—Small Business Health Fairness

- Sec. 231. Short title.
 Sec. 232. Rules governing association health plans.
 Sec. 233. Clarification of treatment of single employer arrangements.
 Sec. 234. Enforcement provisions relating to association health plans.
 Sec. 235. Cooperation between Federal and State authorities.
 Sec. 236. Effective date and transitional and other rules.

TITLE III—INTERSTATE MARKET FOR HEALTH INSURANCE

- Sec. 301. Cooperative governing of individual health insurance coverage.

TITLE IV—SAFETY NET REFORMS

- Sec. 401. Requiring outreach and coverage before expansion of eligibility.
 Sec. 402. Easing administrative barriers to State cooperation with employer-sponsored insurance coverage.
 Sec. 403. Improving beneficiary choice in SCHIP.

TITLE V—MEDICAL LIABILITY REFORMS

- Sec. 501. Short title.
- Sec. 502. Findings and purpose.
- Sec. 503. Encouraging speedy resolution of claims.
- Sec. 504. Compensating patient injury.
- Sec. 505. Maximizing patient recovery.
- Sec. 506. Additional health benefits.
- Sec. 507. Punitive damages.
- Sec. 508. Limitation on recovery in a health care lawsuit based on compliance with best practice guidelines.
- Sec. 509. State grants to create administrative health care tribunals.
- Sec. 510. Authorization of payment of future damages to claimants in health care lawsuits.
- Sec. 511. Definitions.
- Sec. 512. Effect on other laws.
- Sec. 513. State flexibility and protection of States' rights.
- Sec. 514. Applicability; effective date.

TITLE VI—WELLNESS AND PREVENTION

- Sec. 601. Providing financial incentives for treatment compliance.

TITLE VII—TRANSPARENCY AND INSURANCE REFORM MEASURES

- Sec. 701. Receipt and response to requests for claim information.

TITLE VIII—QUALITY

- Sec. 801. Prohibition on certain uses of data obtained from comparative effectiveness research; accounting for personalized medicine and differences in patient treatment response.
- Sec. 802. Establishment of performance-based quality measures.

TITLE IX—STATE TRANSPARENCY PLAN PORTAL

- Sec. 901. Providing information on health coverage options and health care providers.

TITLE X—PATIENT FREEDOM OF CHOICE

- Sec. 1001. Guaranteeing freedom of choice and contracting for patients under Medicare.
- Sec. 1002. Preemption of State laws limiting charges for eligible professional services.
- Sec. 1003. Health care provider licensure cannot be conditioned on participation in a health plan.
- Sec. 1004. Bad debt deduction for doctors to partially offset the cost of providing uncompensated care required to be provided under amendments made by the Emergency Medical Treatment and Labor Act.
- Sec. 1005. Right of contract with health care providers.

TITLE XI—INCENTIVES TO REDUCE PHYSICIAN SHORTAGES

Subtitle A—Federally Supported Student Loan Funds for Medical Students

- Sec. 1101. Federally supported student loan funds for medical students.

Subtitle B—Loan Forgiveness for Primary Care Providers

Sec. 1111. Loan forgiveness for primary care providers.

TITLE XII—QUALITY HEALTH CARE COALITION

Sec. 1201. Quality Health Care Coalition.

TITLE XIII—OFFSETS

Subtitle A—Discretionary Spending Limits

Sec. 1301. Discretionary spending limits.

Subtitle B—Savings From Health Care Efficiencies

Sec. 1311. Medicare DSH report and payment adjustments in response to coverage expansion.

Sec. 1312. Reduction in Medicaid DSH.

Subtitle C—Fraud, Waste, and Abuse

Sec. 1321. Provide adequate funding to HHS OIG and HCFAC.

Sec. 1322. Improved enforcement of the Medicare secondary payor provisions.

Sec. 1323. Strengthen Medicare provider enrollment standards and safeguards.

Sec. 1324. Tracking banned providers across State lines.

1 **SEC. 2. REPEAL OF PPACA AND HEALTH CARE-RELATED**
 2 **HCERA PROVISIONS.**

3 (a) PPACA.—Effective as of the enactment of the
 4 Patient Protection and Affordable Care Act (Public Law
 5 111–148), such Act is repealed, and the provisions of law
 6 amended or repealed by such Act are restored or revived
 7 as if such Act had not been enacted.

8 (b) HEALTH CARE-RELATED PROVISIONS IN THE
 9 HEALTH CARE AND EDUCATION RECONCILIATION ACT OF
 10 2010.—Effective as of the enactment of the Health Care
 11 and Education Reconciliation Act of 2010 (Public Law
 12 111–152), title I and subtitle B of title II of such Act
 13 are repealed, and the provisions of law amended or re-
 14 pealed by such title or subtitle, respectively, are restored

1 or revived as if such title and subtitle had not been en-
2 acted.

3 **TITLE I—TAX INCENTIVES FOR**
4 **MAINTAINING HEALTH IN-**
5 **SURANCE COVERAGE**

6 **SEC. 101. REFUNDABLE TAX CREDIT FOR HEALTH INSUR-**
7 **ANCE COSTS OF LOW-INCOME INDIVIDUALS.**

8 (a) IN GENERAL.—Subpart C of part IV of sub-
9 chapter A of chapter 1 of the Internal Revenue Code of
10 1986 (relating to refundable credits) is amended by insert-
11 ing after section 36A the following new section:

12 **“SEC. 36B. HEALTH INSURANCE COSTS OF LOW-INCOME IN-**
13 **DIVIDUALS.**

14 “(a) IN GENERAL.—In the case of an individual,
15 there shall be allowed as a credit against the tax imposed
16 by subtitle A the aggregate amount paid by the taxpayer
17 for coverage of the taxpayer and the taxpayer’s qualifying
18 family members under qualified health insurance for eligi-
19 ble coverage months beginning in the taxable year.

20 “(b) LIMITATIONS.—

21 “(1) IN GENERAL.—The amount allowable as a
22 credit under subsection (a) for the taxable year shall
23 not exceed the lesser of—

24 “(A) the sum of the monthly limitations
25 for months during such taxable year that the

1 taxpayer or the taxpayer's qualifying family
2 members is an eligible individual, and

3 “(B) the aggregate premiums paid by the
4 taxpayer for the taxable year for coverage de-
5 scribed in subsection (a).

6 “(2) MONTHLY LIMITATION.—The monthly lim-
7 itation for any month is the credit percentage of $\frac{1}{12}$
8 of the sum of—

9 “(A) \$2,000 for coverage of the taxpayer
10 (\$4,000 in the case of a joint return for cov-
11 erage of the taxpayer and the taxpayer's
12 spouse), and

13 “(B) \$500 for coverage of each dependent
14 of the taxpayer.

15 “(3) CREDIT PERCENTAGE.—

16 “(A) IN GENERAL.—For purposes of this
17 section, the term ‘credit percentage’ means 100
18 percent reduced by 1 percentage point for each
19 \$1,000 (or fraction thereof) by which the tax-
20 payer's adjusted gross income for the taxable
21 year exceeds the threshold amount.

22 “(B) THRESHOLD AMOUNT.—For purposes
23 of this paragraph, the term ‘threshold amount’
24 means, with respect to any taxpayer for any
25 taxable year, 200 percent of the Federal pov-

1 erty guideline (as determined by the Secretary
2 of Health and Human Service for the taxable
3 year) applicable to the taxpayer.

4 “(4) ONLY 2 DEPENDENTS TAKEN INTO AC-
5 COUNT.—Not more than 2 dependents of the tax-
6 payer may be taken into account under paragraphs
7 (2)(C) and (3)(B).

8 “(5) INFLATION ADJUSTMENT.—In the case of
9 any taxable year beginning in a calendar year after
10 2011, each dollar amount contained in paragraph
11 (2) shall be increased by an amount equal to—

12 “(A) such dollar amount, multiplied by

13 “(B) the cost-of-living adjustment deter-
14 mined under section 1(f)(3) for the calendar
15 year in which the taxable year begins, deter-
16 mined by substituting ‘calendar year 2010’ for
17 ‘calendar year 1992’ in subparagraph (B)
18 thereof.

19 Any increase determined under the preceding sen-
20 tence shall be rounded to the nearest multiple of
21 \$50.

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

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

5 “(d) QUALIFYING FAMILY MEMBER.—For purposes
6 of this section, the term ‘qualifying family member’
7 means—

8 “(1) in the case of a joint return, the taxpayer’s
9 spouse, and

10 “(2) any dependent of the taxpayer.

11 “(e) QUALIFIED HEALTH INSURANCE.—For pur-
12 poses of this section, the term ‘qualified health insurance’
13 means health insurance coverage (other than excepted
14 benefits as defined in section 9832(c)) which constitutes
15 medical care.

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

19 “(1) COVERAGE UNDER MEDICARE, MEDICAID,
20 OR SCHIP.—Such individual—

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

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

4 “(2) CERTAIN OTHER COVERAGE.—Such indi-
5 vidual—

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

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

10 “(C) is entitled to receive benefits under
11 chapter 17 of title 38, United States Code, or

12 “(D) is enrolled in a group health plan
13 (within the meaning of section 5000(b)(1))
14 which is subsidized by the employer.

15 “(g) SPECIAL RULES.—

16 “(1) COORDINATION WITH ADVANCE PAYMENTS
17 OF CREDIT; RECAPTURE OF EXCESS ADVANCE PAY-
18 MENTS.—With respect to any taxable year—

19 “(A) the amount which would (but for this
20 subsection) be allowed as a credit to the tax-
21 payer under subsection (a) shall be reduced
22 (but not below zero) by the aggregate amount
23 paid on behalf of such taxpayer under section
24 7529 for months beginning in such taxable
25 year, and

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

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

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

11 “(2) COORDINATION WITH OTHER DEDUC-
12 TIONS.—Amounts taken into account under sub-
13 section (a) shall not be taken into account in deter-
14 mining—

15 “(A) any deduction allowed under section
16 162(l), 213, or 224, or

17 “(B) any credit allowed under section 35.

18 “(3) MEDICAL AND HEALTH SAVINGS AC-
19 COUNTS.—Amounts distributed from an Archer
20 MSA (as defined in section 220(d)) or from a health
21 savings account (as defined in section 223(d)) shall
22 not be taken into account under subsection (a).

23 “(4) DENIAL OF CREDIT TO DEPENDENTS AND
24 NONPERMANENT RESIDENT ALIEN INDIVIDUALS.—

1 No credit shall be allowed under this section to any
2 individual who is—

3 “(A) not a citizen or lawful permanent
4 resident of the United States for the calendar
5 year in which the taxable year begins, or

6 “(B) a dependent with respect to another
7 taxpayer for a taxable year beginning in the
8 calendar year in which such individual’s taxable
9 year begins.

10 “(5) INSURANCE WHICH COVERS OTHER INDI-
11 VIDUALS.—For purposes of this section, rules simi-
12 lar to the rules of section 213(d)(6) shall apply with
13 respect to any contract for qualified health insurance
14 under which amounts are payable for coverage of an
15 individual other than the taxpayer and qualifying
16 family members.

17 “(6) TREATMENT OF PAYMENTS.—For pur-
18 poses of this section—

19 “(A) PAYMENTS BY SECRETARY.—Pay-
20 ments made by the Secretary on behalf of any
21 individual under section 7529 (relating to ad-
22 vance payment of credit for health insurance
23 costs of low-income individuals) shall be treated
24 as having been made by the taxpayer on the

1 first day of the month for which such payment
2 was made.

3 “(B) PAYMENTS BY TAXPAYER.—Pay-
4 ments made by the taxpayer for eligible cov-
5 erage months shall be treated as having been
6 made by the taxpayer on the first day of the
7 month for which such payment was made.

8 “(7) REGULATIONS.—The Secretary may pre-
9 scribe such regulations and other guidance as may
10 be necessary or appropriate to carry out this section,
11 section 6050W, and section 7529.”.

12 (b) CONFORMING AMENDMENTS.—

13 (1) Paragraph (2) of section 1324(b) of title
14 31, United States Code, is amended by inserting
15 “36B,” after “36A,”.

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

“Sec. 36B. Health insurance costs of low-income individuals.”.

20 (c) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to taxable years beginning after
22 December 31, 2011.

23 (d) SENSE OF CONGRESS.—It is the sense of Con-
24 gress that the cost of the advanceable refundable credit
25 under sections 36B and 7529 of the Internal Revenue

1 Code of 1986, as added by this title, will be offset by sav-
2 ings derived from the provisions of title XIII.

3 **SEC. 102. ADVANCE PAYMENT OF CREDIT AS PREMIUM**
4 **PAYMENT FOR QUALIFIED HEALTH INSUR-**
5 **ANCE.**

6 (a) IN GENERAL.—Chapter 77 of the Internal Rev-
7 enue Code of 1986 (relating to miscellaneous provisions)
8 is amended by adding at the end the following:

9 **“SEC. 7529. ADVANCE PAYMENT OF CREDIT AS PREMIUM**
10 **PAYMENT FOR QUALIFIED HEALTH INSUR-**
11 **ANCE.**

12 “(a) GENERAL RULE.—Not later than January 1,
13 2012, the Secretary shall establish a program for making
14 payments to providers of qualified health insurance (as de-
15 fined in section 36B(e)) on behalf of taxpayers eligible for
16 the credit under section 36B. Except as otherwise pro-
17 vided by the Secretary, such payments shall be made on
18 the basis of the adjusted gross income of the taxpayer for
19 the preceding taxable year.

20 “(b) CERTIFICATION PROCESS AND PROOF OF COV-
21 ERAGE.—For purposes of this section, payments may be
22 made pursuant to subsection (a) only with respect to indi-
23 viduals for whom a qualified health insurance costs credit
24 eligibility certificate is in effect.”.

1 (b) DISCLOSURE OF RETURN INFORMATION FOR
2 PURPOSES OF ADVANCE PAYMENT OF CREDIT AS PRE-
3 MIUMS FOR QUALIFIED HEALTH INSURANCE.—

4 (1) IN GENERAL.—Subsection (l) of section
5 6103 of such Code is amended by adding at the end
6 the following new paragraph:

7 “(21) DISCLOSURE OF RETURN INFORMATION
8 FOR PURPOSES OF ADVANCE PAYMENT OF CREDIT
9 AS PREMIUMS FOR QUALIFIED HEALTH INSUR-
10 ANCE.—The Secretary may, on behalf of taxpayers
11 eligible for the credit under section 36B, disclose to
12 a provider of qualified health insurance (as defined
13 in section 36(e)), and persons acting on behalf of
14 such provider, return information with respect to
15 any such taxpayer only to the extent necessary (as
16 prescribed by regulations issued by the Secretary) to
17 carry out the program established by section 7529
18 (relating to advance payment of credit as premium
19 payment for qualified health insurance).”.

20 (2) CONFIDENTIALITY OF INFORMATION.—
21 Paragraph (3) of section 6103(a) of such Code is
22 amended by striking “or (20)” and inserting “(20),
23 or (21)”.

1 (3) UNAUTHORIZED DISCLOSURE.—Paragraph
2 (2) of section 7213(a) of such Code is amended by
3 striking “or (20)” and inserting “(20), or (21)”.

4 (c) INFORMATION REPORTING.—

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

10 **“SEC. 6050X. RETURNS RELATING TO CREDIT FOR HEALTH**
11 **INSURANCE COSTS OF LOW-INCOME INDIVID-**
12 **UALS.**

13 “(a) REQUIREMENT OF REPORTING.—Every person
14 who is entitled to receive payments for any month of any
15 calendar year under section 7529 (relating to advance pay-
16 ment of credit as premium payment for qualified health
17 insurance) with respect to any individual shall, at such
18 time as the Secretary may prescribe, make the return de-
19 scribed in subsection (b) with respect to each such indi-
20 vidual.

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

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

25 “(2) contains—

1 “(A) the name, address, and TIN of each
2 individual referred to in subsection (a),

3 “(B) the number of months for which
4 amounts were entitled to be received with re-
5 spect to such individual under section 7529 (re-
6 lating to advance payment of credit as premium
7 payment for qualified health insurance),

8 “(C) the amount entitled to be received for
9 each such month, and

10 “(D) such other information as the Sec-
11 retary may prescribe.

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

18 “(1) the name and address of the person re-
19 quired to make such return and the phone number
20 of the information contact for such person, and

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

23 The written statement required under the preceding sen-
24 tence shall be furnished on or before January 31 of the

1 year following the calendar year for which the return
2 under subsection (a) is required to be made.”.

3 (2) ASSESSABLE PENALTIES.—

4 (A) Subparagraph (B) of section
5 6724(d)(1) of such Code (relating to defini-
6 tions) is amended by striking “or” at the end
7 of clause (xxii), by striking “and” at the end of
8 clause (xxiii) and inserting “or”, and by insert-
9 ing after clause (xxiii) the following new clause:

10 “(xxiv) section 6050X (relating to re-
11 turns relating to credit for health insur-
12 ance costs of low-income individuals),
13 and”.

14 (B) Paragraph (2) of section 6724(d) of
15 such Code is amended by striking “or” at the
16 end of subparagraph (EE), by striking the pe-
17 riod at the end of subparagraph (FF) and in-
18 serting “, or”, and by adding after subpara-
19 graph (FF) the following new subparagraph:

20 “(GG) section 6050X (relating to returns
21 relating to credit for health insurance costs of
22 low-income individuals).”.

23 (d) CLERICAL AMENDMENTS.—

1 (1) The table of sections for chapter 77 of such
2 Code is amended by adding at the end the following
3 new item:

“Sec. 7529. Advance payment of credit as premium payment for qualified health insurance.”.

4 (2) The table of sections for subpart B of part
5 III of subchapter A of chapter 61 of such Code is
6 amended by adding at the end the following new
7 item:

“Sec. 6050X. Returns relating to credit for health insurance costs of low-income individuals.”.

8 (e) EFFECTIVE DATE.—The amendments made by
9 this section shall take effect on the date of the enactment
10 of this Act.

11 **SEC. 103. ELECTION OF TAX CREDIT INSTEAD OF ALTER-**
12 **NATIVE GOVERNMENT OR GROUP PLAN BEN-**
13 **EFITS.**

14 (a) IN GENERAL.—Notwithstanding any other provi-
15 sion of law, an individual who is otherwise eligible for ben-
16 efits under a health program (as defined in subsection (e))
17 may elect, in a form and manner specified by the Sec-
18 retary of Health and Human Services in consultation with
19 the Secretary of the Treasury, to receive a tax credit de-
20 scribed in section 36B of the Internal Revenue Code of
21 1986 (which may be used for the purpose of health insur-
22 ance coverage) in lieu of receiving any benefits under such
23 program.

1 (b) EFFECTIVE DATE.—An election under subsection
2 (a) may first be made for calendar year 2012 and any
3 such election shall be effective for such period (not less
4 than one calendar year) as the Secretary of Health and
5 Human Services shall specify, in consultation with the
6 Secretary of the Treasury.

7 (c) HEALTH PROGRAM DEFINED.—For purposes of
8 this section, the term “health program” means any of the
9 following:

10 (1) MEDICARE.—The Medicare program under
11 part A of title XVIII of the Social Security Act.

12 (2) MEDICAID.—The Medicaid program under
13 title XIX of such Act (including such a program op-
14 erating under a Statewide waiver under section 1115
15 of such Act).

16 (3) SCHIP.—The State children’s health insur-
17 ance program under title XXI of such Act.

18 (4) TRICARE.—The TRICARE program
19 under chapter 55 of title 10, United States Code.

20 (5) VETERANS BENEFITS.—Coverage for bene-
21 fits under chapter 17 of title 38, United States
22 Code.

23 (6) FEHBP.—Coverage under chapter 89 of
24 title 5, United States Code.

1 the average value of the national health exclusion for em-
2 ployer sponsored insurance as determined by calculating
3 the value of the exclusion for each household followed by
4 calculating the average of those values.

5 “(c) QUALIFIED HEALTH INSURANCE.—For pur-
6 poses of this section, the term ‘qualified health insurance’
7 has the meaning given such term by section 36B(e).

8 “(d) SPECIAL RULES.—

9 “(1) COORDINATION WITH MEDICAL DEDUC-
10 TION, ETC.—Any amount paid by a taxpayer for in-
11 surance to which subsection (a) applies shall not be
12 taken into account in computing the amount allow-
13 able to the taxpayer as a deduction under section
14 162(l) or 213(a). Any amount taken into account in
15 determining the credit allowed under section 35 or
16 36B shall not be taken into account for purposes of
17 this section.

18 “(2) DEDUCTION NOT ALLOWED FOR SELF-EM-
19 PLOYMENT TAX PURPOSES.—The deduction allow-
20 able by reason of this section shall not be taken into
21 account in determining an individual’s net earnings
22 from self-employment (within the meaning of section
23 1402(a)) for purposes of chapter 2.”.

24 (b) DEDUCTION ALLOWED IN COMPUTING AD-
25 JUSTED GROSS INCOME.—Subsection (a) of section 62 of

1 such Code is amended by inserting before the last sentence
2 the following new paragraph:

3 “(22) COSTS OF QUALIFIED HEALTH INSUR-
4 ANCE.—The deduction allowed by section 224.”.

5 (c) CLERICAL AMENDMENT.—The table of sections
6 for part VII of subchapter B of chapter 1 of such Code
7 is amended by redesignating the item relating to section
8 224 as an item relating to section 225 and inserting before
9 such item the following new item:

“Sec. 224. Costs of qualified health insurance.”.

10 (d) EFFECTIVE DATE.—The amendments made by
11 this section shall apply to taxable years beginning after
12 December 31, 2011.

13 **SEC. 105. LIMITATION ON ABORTION FUNDING.**

14 No funds authorized under, or credits or deductions
15 allowed under the Internal Revenue Code of 1986 by rea-
16 son of, this Act (or any amendment made by this Act)
17 may be used to pay for any abortion or to cover any part
18 of the costs of any health plan that includes coverage of
19 abortion, except in the case where a woman suffers from
20 a physical disorder, physical injury, or physical illness that
21 would, as certified by a physician, place the woman in dan-
22 ger of death unless an abortion is performed, including
23 a life-endangering physical condition caused by or arising
24 from the pregnancy itself, or unless the pregnancy is the
25 result of an act of rape or incest.

1 **SEC. 106. NO GOVERNMENT DISCRIMINATION AGAINST**
2 **CERTAIN HEALTH CARE ENTITIES.**

3 (a) **NON-DISCRIMINATION.**—A Federal agency or
4 program, and any State or local government that receives
5 Federal financial assistance under this Act or any amend-
6 ment made by this Act (either directly or indirectly), may
7 not subject any individual or institutional health care enti-
8 ty to discrimination on the basis that the health care enti-
9 ty does not provide, pay for, provide coverage of, or refer
10 for abortions.

11 (b) **HEALTH CARE ENTITY DEFINED.**—For purposes
12 of this section, the term “health care entity” includes an
13 individual physician or other health care professional, a
14 hospital, a provider-sponsored organization, a health
15 maintenance organization, a health insurance plan, or any
16 other kind of health care facility, organization, or plan.

17 (c) **REMEDIES.**—

18 (1) **IN GENERAL.**—The courts of the United
19 States shall have jurisdiction to prevent and redress
20 actual or threatened violations of this section by
21 issuing any form of legal or equitable relief, includ-
22 ing—

23 (A) injunctions prohibiting conduct that
24 violates this section; and

25 (B) orders preventing the disbursement of
26 all or a portion of Federal financial assistance

1 to a State or local government, or to a specific
2 offending agency or program of a State or local
3 government, until such time as the conduct pro-
4 hibited by this section has ceased.

5 (2) COMMENCEMENT OF ACTION.—An action
6 under this subsection may be instituted by—

7 (A) any health care entity that has stand-
8 ing to complain of an actual or threatened vio-
9 lation of this section; or

10 (B) the Attorney General of the United
11 States.

12 (d) ADMINISTRATION.—The Secretary of Health and
13 Human Services shall designate the Director of the Office
14 for Civil Rights of the Department of Health and Human
15 Services—

16 (1) to receive complaints alleging a violation of
17 this section;

18 (2) subject to paragraph (3), to pursue the in-
19 vestigation of such complaints in coordination with
20 the Attorney General; and

21 (3) in the case of a complaint related to a Fed-
22 eral agency (other than with respect to the Depart-
23 ment of Health and Human Services) or program
24 administered through such other agency or any
25 State or local government receiving Federal financial

1 assistance through such other agency, to refer the
2 complaint to the appropriate office of such other
3 agency.

4 **SEC. 107. EQUAL EMPLOYER CONTRIBUTION RULE TO PRO-**
5 **MOTE CHOICE.**

6 (a) **EXCISE TAX FOR FAILURE TO PROVIDE CON-**
7 **TRIBUTION ELECTION.**—Section 5000 of the Internal
8 Revenue Code of 1986 is amended by adding at the end
9 the following new subsection:

10 “(e) **HEALTH CARE CONTRIBUTION ELECTION.**—

11 “(1) **IN GENERAL.**—Subsection (a) shall not
12 apply in the case of a group health plan with respect
13 to which the requirements of paragraphs (2) and (3)
14 are met.

15 “(2) **CONTRIBUTION ELECTION.**—The require-
16 ment of this paragraph is met with respect to a
17 group health plan if any employee of an employer
18 (who but for this paragraph would be covered by
19 such plan) may elect to have the employer or em-
20 ployee organization pay an amount which is not less
21 than the contribution amount to any provider of
22 health insurance coverage (other than excepted bene-
23 fits as defined in section 9832(c)) which constitutes
24 medical care of the individual or individual’s spouse
25 or dependents in lieu of such group health plan cov-

1 erage otherwise provided or contributed to by the
2 employer with respect to such employee.

3 “(3) PRE-EXISTING CONDITIONS.—

4 “(A) IN GENERAL.—The requirement of
5 this paragraph is met with respect to health in-
6 surance coverage provided to a participant or
7 beneficiary by any health insurance issuer if,
8 under such plan the requirements of section
9 9801 are met with respect to the participant or
10 beneficiary.

11 “(B) ENFORCEMENT WITH RESPECT TO
12 INDIVIDUAL ELECTION.—For purposes of sub-
13 paragraph (A), any health insurance coverage
14 with respect to the participant or beneficiary
15 shall be treated as health insurance coverage
16 under a group health plan to which section
17 9801 applies.

18 “(4) CONTRIBUTION AMOUNT.—For purposes
19 of this section, the term ‘contribution amount’
20 means, with respect to an individual under a group
21 health plan, the portion of the applicable premium of
22 such individual under such plan (as determined
23 under section 4980B(f)(4)) which is not paid by the
24 individual. In the case that the employer offers more
25 than one group health plan, the contribution amount

1 shall be the average amount of the applicable pre-
2 miums under such plans.

3 “(5) GROUP HEALTH PLAN.—For purpose of
4 this subsection, subsection (d) shall not apply.

5 “(6) APPLICATION TO FEHBP.—Notwith-
6 standing any other provision of law, the Office of
7 Personnel Management shall carry out the health
8 benefits program under chapter 89 of title 5, United
9 States Code, consistent with the requirements of this
10 subsection.”.

11 (b) REQUIREMENT OF EQUAL CONTRIBUTIONS TO
12 ALL FEHBP PLANS.—Section 8906 of title 5, United
13 States Code, is amended by adding at the end the fol-
14 lowing new subsection:

15 “(j) Notwithstanding the previous provisions of this
16 section the Office of Personnel Management shall revise
17 the amount of the Government contribution made under
18 this section in a manner so that—

19 “(1) the amount of such contribution does not
20 change based on the health benefits plan in which
21 the individual is enrolled; and

22 “(2) the aggregate amount of such contribu-
23 tions is estimated to be equal to the aggregate
24 amount of such contributions if this subsection did
25 not apply.”.

1 (c) ERISA CONFORMING AMENDMENTS.—

2 (1) EXCEPTION FROM HIPAA REQUIREMENTS
3 FOR BENEFITS PROVIDED UNDER HEALTH CARE
4 CONTRIBUTION ELECTION.—Section 732 of the Em-
5 ployee Retirement Income Security Act of 1974 (29
6 U.S.C. 1191a) is amended by adding at the end the
7 following new subsection:

8 “(e) HEALTH CARE CONTRIBUTION ELECTION.—

9 “(1) IN GENERAL.—The requirements of this
10 part shall not apply in the case of health insurance
11 coverage (other than excepted benefits as defined in
12 section 9832(e) of the Internal Revenue Code of
13 1986)—

14 “(A) which is provided to a participant or
15 beneficiary by a health insurance issuer under
16 a group health plan, and

17 “(B) with respect to which the require-
18 ments of paragraphs (2) and (3) are met.

19 “(2) CONTRIBUTION ELECTION.—The require-
20 ment of this paragraph is met with respect to health
21 insurance coverage provided to a participant or ben-
22 efiiciary by any health insurance issuer under a
23 group health plan if, under such plan—

24 “(A) the participant may elect such cov-
25 erage for any period of coverage in lieu of

1 health insurance coverage otherwise provided
2 under such plan for such period, and

3 “(B) in the case of such an election, the
4 plan sponsor is required to pay to such issuer
5 for the elected coverage for such period an
6 amount which is not less than the contribution
7 amount for such health insurance coverage oth-
8 erwise provided under such plan for such pe-
9 riod.

10 “(3) PRE-EXISTING CONDITIONS.—

11 “(A) IN GENERAL.—The requirement of
12 this paragraph is met with respect to health in-
13 surance coverage provided to a participant or
14 beneficiary by any health insurance issuer if,
15 under such plan the requirements of section
16 701 are met with respect to the participant or
17 beneficiary.

18 “(B) ENFORCEMENT WITH RESPECT TO
19 INDIVIDUAL ELECTION.—For purposes of sub-
20 paragraph (A), any health insurance coverage
21 with respect to the participant or beneficiary
22 shall be treated as health insurance coverage
23 under a group health plan to which section 701
24 applies.

25 “(4) CONTRIBUTION AMOUNT.—

1 “(A) IN GENERAL.—For purposes of this
2 section, the term ‘contribution amount’ means,
3 with respect to any period of health insurance
4 coverage offered to a participant or beneficiary,
5 the portion of the applicable premium of such
6 participant or beneficiary under such plan
7 which is not paid by such participant or bene-
8 ficiary. In the case that the employer offers
9 more than one group health plan, the contribu-
10 tion amount shall be the average amount of the
11 applicable premiums under such plans.

12 “(B) APPLICABLE PREMIUM.—For pur-
13 poses of subparagraph (A), the term ‘applicable
14 premium’ means, with respect to any period of
15 health insurance coverage of a participant or
16 beneficiary under a group health plan, the cost
17 to the plan for such period of such coverage for
18 similarly situated beneficiaries (without regard
19 to whether such cost is paid by the plan spon-
20 sor or the participant or beneficiary).”.

21 (2) EXEMPTION FROM FIDUCIARY LIABILITY.—
22 Section 404 of such Act (29 U.S.C. 1104) is amend-
23 ed by adding at the end the following new sub-
24 section:

1 “(e) The plan sponsor of a group health plan (as de-
2 fined in section 733(a)) shall not be treated as breaching
3 any of the responsibilities, obligations, or duties imposed
4 upon fiduciaries by this title in the case of any individual
5 who is a participant or beneficiary under such plan solely
6 because of the extent to which the plan sponsor provides,
7 in the case of such individual, some or all of such benefits
8 by means of payment of contribution amounts pursuant
9 to a contribution election under section 732(e), irrespec-
10 tive of the amount or type of benefits that would otherwise
11 be provided to such individual under such plan.”.

12 (d) EXCEPTION FROM HIPAA REQUIREMENTS
13 UNDER IRC FOR BENEFITS PROVIDED UNDER HEALTH
14 CARE CONTRIBUTION ELECTION.—Section 9831 of the
15 Internal Revenue Code of 1986 (relating to general excep-
16 tions) is amended by adding at the end the following new
17 subsection:

18 “(d) HEALTH CARE CONTRIBUTION ELECTION.—

19 “(1) IN GENERAL.—The requirements of this
20 chapter shall not apply in the case of health insur-
21 ance coverage (other than excepted benefits as de-
22 fined in section 9832(c))—

23 “(A) which is provided to a participant or
24 beneficiary by a health insurance issuer under
25 a group health plan, and

1 “(B) with respect to which the require-
2 ments of paragraphs (2) and (3) are met.

3 “(2) CONTRIBUTION ELECTION.—The require-
4 ment of this paragraph is met with respect to health
5 insurance coverage provided to a participant or ben-
6 eficiary by any health insurance issuer under a
7 group health plan if, under such plan—

8 “(A) the participant may elect such cov-
9 erage for any period of coverage in lieu of
10 health insurance coverage otherwise provided
11 under such plan for such period, and

12 “(B) in the case of such an election, the
13 plan sponsor is required to pay to such issuer
14 for the elected coverage for such period an
15 amount which is not less than the contribution
16 amount for such health insurance coverage oth-
17 erwise provided under such plan for such pe-
18 riod.

19 “(3) PRE-EXISTING CONDITIONS.—

20 “(A) IN GENERAL.—The requirement of
21 this paragraph is met with respect to health in-
22 surance coverage provided to a participant or
23 beneficiary by any health insurance issuer if,
24 under such plan the requirements of section

1 9801 are met with respect to the participant or
2 beneficiary.

3 “(B) ENFORCEMENT WITH RESPECT TO
4 INDIVIDUAL ELECTION.—For purposes of sub-
5 paragraph (A), any health insurance coverage
6 with respect to the participant or beneficiary
7 shall be treated as health insurance coverage
8 under a group health plan to which section
9 9801 applies.

10 “(4) CONTRIBUTION AMOUNT.—

11 “(A) IN GENERAL.—For purposes of this
12 subsection, the term ‘contribution amount’
13 means, with respect to any period of health in-
14 surance coverage offered to a participant or
15 beneficiary, the portion of the applicable pre-
16 mium of such participant or beneficiary under
17 such plan which is not paid by such participant
18 or beneficiary. In the case that the employer of-
19 fers more than one group health plan, the con-
20 tribution amount shall be the average amount
21 of the applicable premiums under such plans.

22 “(B) APPLICABLE PREMIUM.—For pur-
23 poses of subparagraph (A), the term ‘applicable
24 premium’ means, with respect to any period of
25 health insurance coverage of a participant or

1 beneficiary under a group health plan, the cost
2 to the plan for such period of such coverage for
3 similarly situated beneficiaries (without regard
4 to whether such cost is paid by the plan spon-
5 sor or the participant or beneficiary).”.

6 (e) EXCEPTION FROM HIPAA REQUIREMENTS
7 UNDER THE PHSA FOR BENEFITS PROVIDED UNDER
8 HEALTH CARE CONTRIBUTION ELECTION.—Section 2721
9 of the Public Health Service Act (42 U.S.C. 300gg–21)
10 is amended—

11 (1) by redesignating subsection (e) as sub-
12 section (f); and

13 (2) by inserting after subsection (d) the fol-
14 lowing new subsection:

15 “(e) HEALTH CARE CONTRIBUTION ELECTION.—

16 “(1) IN GENERAL.—The requirements of sub-
17 parts 1 through 3 shall not apply in the case of
18 health insurance coverage (other than excepted bene-
19 fits as defined in section 9832(c) of the Internal
20 Revenue Code of 1986)—

21 “(A) which is provided to a participant or
22 beneficiary by a health insurance issuer under
23 a group health plan, and

24 “(B) with respect to which the require-
25 ments of paragraphs (2) and (3) are met.

1 “(2) CONTRIBUTION ELECTION.—The require-
2 ment of this paragraph is met with respect to health
3 insurance coverage provided to a participant or ben-
4 eficiary by any health insurance issuer under a
5 group health plan if, under such plan—

6 “(A) the participant may elect such cov-
7 erage for any period of coverage in lieu of
8 health insurance coverage otherwise provided
9 under such plan for such period, and

10 “(B) in the case of such an election, the
11 plan sponsor is required to pay to such issuer
12 for the elected coverage for such period an
13 amount which is not less than the contribution
14 amount for such health insurance coverage oth-
15 erwise provided under such plan for such pe-
16 riod.

17 “(3) PRE-EXISTING CONDITIONS.—

18 “(A) IN GENERAL.—The requirement of
19 this paragraph is met with respect to health in-
20 surance coverage provided to a participant or
21 beneficiary by any health insurance issuer if,
22 under such plan the requirements of section
23 2701 are met with respect to the participant or
24 beneficiary.

1 “(B) ENFORCEMENT WITH RESPECT TO
2 INDIVIDUAL ELECTION.—For purposes of sub-
3 paragraph (A), any health insurance coverage
4 with respect to the participant or beneficiary
5 shall be treated as health insurance coverage
6 under a group health plan to which section
7 2701 applies.

8 “(4) CONTRIBUTION AMOUNT.—

9 “(A) IN GENERAL.—For purposes of this
10 section, the term ‘contribution amount’ means,
11 with respect to any period of health insurance
12 coverage offered to a participant or beneficiary,
13 the portion of the applicable premium of such
14 participant or beneficiary under such plan
15 which is not paid by such participant or bene-
16 ficiary. In the case that the employer offers
17 more than one group health plan, the contribu-
18 tion amount shall be the average amount of the
19 applicable premiums under such plans.

20 “(B) APPLICABLE PREMIUM.—For pur-
21 poses of subparagraph (A), the term ‘applicable
22 premium’ means, with respect to any period of
23 health insurance coverage of a participant or
24 beneficiary under a group health plan, the cost
25 to the plan for such period of such coverage for

1 similarly situated beneficiaries (without regard
2 to whether such cost is paid by the plan spon-
3 sor or the participant or beneficiary).”.

4 **SEC. 108. LIMITATIONS ON STATE RESTRICTIONS ON EM-**
5 **PLOYER AUTO-ENROLLMENT.**

6 (a) IN GENERAL.—No State shall establish a law
7 that prevents an employer from instituting auto-enroll-
8 ment which meets the requirements of subsection (b) for
9 coverage of a participant or beneficiary under a group
10 health plan, or health insurance coverage offered in con-
11 nection with such a plan, so long as the participant or
12 beneficiary has the option of declining such coverage.

13 (b) AUTOMATIC ENROLLMENT FOR EMPLOYER
14 SPONSORED HEALTH BENEFITS.—

15 (1) IN GENERAL.—The requirement of this sub-
16 section with respect to an employer and an employee
17 is that the employer automatically enroll such em-
18 ployee into the employment-based health benefits
19 plan for individual coverage under the plan option
20 with the lowest applicable employee premium.

21 (2) OPT-OUT.—In no case may an employer
22 automatically enroll an employee in a plan under
23 paragraph (1) if such employee makes an affirmative
24 election to opt-out of such plan or to elect coverage
25 under an employment-based health benefits plan of-

1 ferred by such employer. An employer shall provide
2 an employee with a 30-day period to make such an
3 affirmative election before the employer may auto-
4 matically enroll the employee in such a plan.

5 (3) NOTICE REQUIREMENTS.—

6 (A) IN GENERAL.—Each employer de-
7 scribed in paragraph (1) who automatically en-
8 rolls an employee into a plan as described in
9 such paragraph shall provide the employees,
10 within a reasonable period before the beginning
11 of each plan year (or, in the case of new em-
12 ployees, within a reasonable period before the
13 end of the enrollment period for such a new em-
14 ployee), written notice of the employees' rights
15 and obligations relating to the automatic enroll-
16 ment requirement under such paragraph. Such
17 notice must be comprehensive and understood
18 by the average employee to whom the automatic
19 enrollment requirement applies.

20 (B) INCLUSION OF SPECIFIC INFORMA-
21 TION.—The written notice under subparagraph
22 (A) must explain an employee's right to opt out
23 of being automatically enrolled in a plan and in
24 the case that more than one level of benefits or
25 employee premium level is offered by the em-

1 **“SEC. 45R. AUTO-ENROLLMENT AND DEFINED CONTRIBU-**
2 **TION OPTION FOR HEALTH BENEFITS PLANS**
3 **OF SMALL EMPLOYERS.**

4 “(a) IN GENERAL.—For purposes of section 38, in
5 the case of a small employer, the health benefits plan im-
6 plementation credit determined under this section for the
7 taxable year is an amount equal to 100 percent of the
8 amount paid or incurred by the taxpayer during the tax-
9 able year for qualified health benefits expenses.

10 “(b) LIMITATION.—The credit determined under sub-
11 section (a) with respect to any taxpayer for any taxable
12 year shall not exceed the excess of—

13 “(1) \$1,500, over

14 “(2) sum of the credits determined under sub-
15 section (a) with respect to such taxpayer for all pre-
16 ceding taxable years.

17 “(c) QUALIFIED HEALTH BENEFITS EXPENSES.—
18 For purposes of this section, the term ‘qualified health
19 benefits auto-enrollment expenses’ means, with respect to
20 any taxable year, amounts paid or incurred by the tax-
21 payer during such taxable year for—

22 “(1) establishing auto-enrollment which meets
23 the requirements of section 107 of the Empowering
24 Patients First Act for coverage of a participant or
25 beneficiary under a group health plan, or health in-

1 surance coverage offered in connection with such a
2 plan, and

3 “(2) implementing the employer contribution
4 option for health insurance coverage pursuant to
5 section 5000(e)(2).

6 “(d) QUALIFIED SMALL EMPLOYER.—For purposes
7 of this section, the term ‘qualified small employer’ means
8 any employer for any taxable year if the number of em-
9 ployees employed by such employer during such taxable
10 year does not exceed 50. All employers treated as a single
11 employer under section (a) or (b) of section 52 shall be
12 treated as a single employer for purposes of this section.

13 “(e) NO DOUBLE BENEFIT.—No deduction or credit
14 shall be allowed under any other provision of this chapter
15 with respect to the amount of the credit determined under
16 this section.

17 “(f) TERMINATION.—Subsection (a) shall not apply
18 to any taxable year beginning after the date which is 2
19 years after the date of the enactment of this section.”.

20 (b) CREDIT TO BE PART OF GENERAL BUSINESS
21 CREDIT.—Subsection (b) of section 38 of such Code (re-
22 lating to general business credit) is amended by striking
23 “plus” at the end of paragraph (34), by striking the period
24 at the end of paragraph (35) and inserting “, plus” , and
25 by adding at the end the following new paragraph:

1 “(36) in the case of a small employer (as de-
2 fined in section 45R(d)), the health benefits plan im-
3 plementation credit determined under section
4 45R(a).”.

5 (c) CLERICAL AMENDMENT.—The table of sections
6 for subpart D of part IV of subchapter A of chapter 1
7 of such Code is amended by inserting after the item relat-
8 ing to section 45Q the following new item:

 “Sec. 45R. Auto-enrollment and defined contribution option for health benefits
 plans of small employers.”.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to taxable years beginning after
11 the date of the enactment of this Act.

12 **SEC. 110. HSA MODIFICATIONS AND CLARIFICATIONS.**

13 (a) CLARIFICATION OF TREATMENT OF CAPITATED
14 PRIMARY CARE PAYMENTS AS AMOUNTS PAID FOR MED-
15 ICAL CARE.—Section 213(d) of the Internal Revenue Code
16 of 1986 (relating to definitions) is amended by adding at
17 the end the following new paragraph:

18 “(12) TREATMENT OF CAPITATED PRIMARY
19 CARE PAYMENTS.—Capitated primary care payments
20 shall be treated as amounts paid for medical care.”.

21 (b) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR
22 VETERANS OR INDIAN HEALTH BENEFITS.—Section
23 223(c)(1) of such Code (defining eligible individual) is

1 amended by adding at the end the following new subpara-
2 graph:

3 “(C) SPECIAL RULE FOR INDIVIDUALS ELI-
4 GIBLE FOR VETERANS OR INDIAN HEALTH BEN-
5 EFITS.—For purposes of subparagraph (A)(ii),
6 an individual shall not be treated as covered
7 under a health plan described in such subpara-
8 graph merely because the individual receives
9 periodic hospital care or medical services under
10 any law administered by the Secretary of Vet-
11 erans Affairs or the Bureau of Indian Affairs.”.

12 (c) CERTAIN PHYSICIAN FEES TO BE TREATED AS
13 MEDICAL CARE.—Section 213(d) of such Code is amend-
14 ed by adding at the end the following new paragraph:

15 “(13) PRE-PAID PHYSICIAN FEES.—The term
16 ‘medical care’ shall include amounts paid by patients
17 to their primary physician in advance for the right
18 to receive medical services on an as-needed basis.”.

19 (d) EFFECTIVE DATE.—The amendment made by
20 this section shall apply to taxable years beginning after
21 the date of the enactment of this Act.

1 **TITLE II—HEALTH INSURANCE**
2 **POOLING MECHANISMS FOR**
3 **INDIVIDUALS**

4 **Subtitle A—Safety Net for Individ-**
5 **uals With Pre-Existing Condi-**
6 **tions**

7 **SEC. 201. REQUIRING OPERATION OF HIGH-RISK POOL OR**
8 **OTHER MECHANISM AS CONDITION FOR**
9 **AVAILABILITY OF TAX CREDIT.**

10 No credit shall be allowed under section 36B of the
11 Internal Revenue Code of 1986 (relating to health insur-
12 ance costs of low-income individuals) to the residents of
13 any State unless such State meets the following require-
14 ments:

15 (1) The State must implement a high-risk pool
16 or a reinsurance pool or other risk-adjustment mech-
17 anism (as defined in section 211(h)).

18 (2) Assessments levied by the State for pur-
19 poses of funding such a pool or mechanism must
20 only be used for funding and administering such
21 pool or mechanism.

22 (3) Such pool or mechanism must incorporate
23 the application of such tax credit into such pool or
24 mechanism.

1 **Subtitle B—Federal Block Grants**
2 **for State Insurance Expenditures**

3 **SEC. 211. FEDERAL BLOCK GRANTS FOR STATE INSURANCE**
4 **EXPENDITURES.**

5 (a) IN GENERAL.—Subject to the succeeding provi-
6 sions of this section, each State shall receive from the Sec-
7 retary of Health and Human Services (in this subtitle re-
8 ferred to as the “Secretary”) a block grant for the State’s
9 providing for the use, in connection with providing health
10 benefits coverage, of a qualifying high-risk pool or a rein-
11 surance pool or other risk-adjustment mechanism used for
12 the purpose of subsidizing the purchase of private health
13 insurance.

14 (b) FUNDING AMOUNT.—

15 (1) IN GENERAL.—There are hereby appro-
16 priated, out of any funds in the Treasury not other-
17 wise appropriated, \$300,000,000 for fiscal year
18 2012 and each subsequent fiscal year for block
19 grants under this section. Such amount shall be di-
20 vided among the States as determined by the Sec-
21 retary.

22 (2) CONSTRUCTION.—Nothing in this section
23 shall be construed as preventing a State from using
24 funding under section 2745 of the Public Health

1 Service Act for purposes of funding reinsurance or
2 other risk mechanisms.

3 (c) LIMITATION.—Funding under subsection (a) may
4 only be used for the following:

5 (1) QUALIFYING HIGH-RISK POOLS.—

6 (A) CURRENT POOLS.—A qualifying high-
7 risk pool created before the date of the enact-
8 ment of this Act that only cover high-risk popu-
9 lations and individuals (and their spouse and
10 dependents) receiving a health care tax credit
11 under section 35 of the Internal Revenue Code
12 of 1986 for a limited period of time as deter-
13 mined by the Secretary or under section 2741
14 of Public Health Service Act.

15 (B) NEW POOLS.—A qualifying high-risk
16 pool created on or after such date that only cov-
17 ers populations and individuals described in
18 subparagraph (A) if the pool—

19 (i) offers at least the option of one or
20 more high-deductible plan options, in com-
21 bination with a contribution into a health
22 savings account;

23 (ii) offers multiple competing health
24 plan options; and

25 (iii) covers only high-risk populations.

1 (2) RISK INSURANCE POOL OR OTHER RISK-AD-
2 JUSTMENT MECHANISMS.—

3 (A) CURRENT REINSURANCE.—A reinsur-
4 ance pool, or other risk-adjustment mechanism,
5 created before the date of the enactment of this
6 Act that only covers populations and individuals
7 described in paragraph (1)(A).

8 (B) NEW POOLS.—A reinsurance pool or
9 other risk-adjustment mechanism created on or
10 after such date that provides reinsurance only
11 covers populations and individuals described in
12 paragraph (1)(A) and only on a prospective
13 basis under which a health insurance issuer
14 cedes covered lives to the pool in exchange for
15 payment of a reinsurance premium.

16 (3) TRANSITION.—Nothing in this section shall
17 be construed as preventing a State from using funds
18 available to transition from an existing high-risk
19 pool to a reinsurance pool.

20 (d) BONUS PAYMENTS.—With respect to any
21 amounts made available to the States under this section,
22 the Secretary shall set aside a portion of such amounts
23 that shall only be available for the following activities by
24 such States:

1 (1) Providing guaranteed availability of indi-
2 vidual health insurance coverage to certain individ-
3 uals with prior group coverage under part B of title
4 XXVII of the Public Health Service Act.

5 (2) A reduction in premium trends, actual pre-
6 miums, or other cost-sharing requirements.

7 (3) An expansion or broadening of the pool of
8 high-risk individuals eligible for coverage.

9 (4) States that adopt the Model Health Plan
10 for Uninsurable Individuals Act of the National As-
11 sociation of Insurance Commissioners (if and when
12 updated by such Association).

13 The Secretary may request such Association to update
14 such Model Health Plan as needed by 2013.

15 (e) ADMINISTRATION.—The Secretary shall provide
16 for the administration of this section and may establish
17 such terms and conditions, including the requirement of
18 an application, as may be appropriate to carry out this
19 section.

20 (f) CONSTRUCTION.—Nothing in this section shall be
21 construed as requiring a State to operate a reinsurance
22 pool (or other risk-adjustment mechanism) under this sec-
23 tion or as preventing a State from operating such a pool
24 or mechanism through one or more private entities.

1 (g) QUALIFYING HIGH-RISK POOL.—For purposes of
2 this section, the term “qualifying high-risk pool” means
3 any qualified high-risk pool (as defined in subsection
4 (g)(1)(A) of section 2745) of the Public Health Service
5 Act) that meets the conditions to receive a grant under
6 section (b)(1) of such section.

7 (h) REINSURANCE POOL OR OTHER RISK-ADJUST-
8 MENT MECHANISM DEFINED.—For purposes of this sec-
9 tion, the term “reinsurance pool or other risk-adjustment
10 mechanism” means any State-based risk spreading mecha-
11 nism to subsidize the purchase of private health insurance
12 for the high-risk population.

13 (i) HIGH-RISK POPULATION.—For purposes of this
14 section, the term “high-risk population” means—

15 (1) individuals who, by reason of the existence
16 or history of a medical condition, are able to acquire
17 health coverage only at rates which are at least 150
18 percent of the standard risk rates for such coverage
19 (in a non-community-rated non-guaranteed issue
20 State), and

21 (2) individuals who are provided health cov-
22 erage by a high-risk pool.

23 (j) STATE DEFINED.—For purposes of this section,
24 the term “State” includes the District of Columbia, Puer-

1 to Rico, the Virgin Islands, Guam, American Samoa, and
 2 the Northern Mariana Islands.

3 (k) EXTENDING FUNDING.—Section 2745(d)(2) of
 4 the Public Health Service Act (42 U.S.C. 300gg–45(d)(2))
 5 is amended by striking “2010” and inserting “2014” each
 6 place it appears.

7 **Subtitle C—Health Care Access and** 8 **Availability**

9 **SEC. 221. EXPANSION OF ACCESS AND CHOICE THROUGH** 10 **INDIVIDUAL MEMBERSHIP ASSOCIATIONS** 11 **(IMAS).**

12 The Public Health Service Act, as amended by sec-
 13 tion 2, is further amended by inserting after title XXX
 14 the following new title:

15 **“TITLE XXXI—INDIVIDUAL** 16 **MEMBERSHIP ASSOCIATIONS**

17 **“SEC. 3101. DEFINITION OF INDIVIDUAL MEMBERSHIP AS-** 18 **SOCIATION (IMA).**

19 “(a) IN GENERAL.—For purposes of this title, the
 20 terms ‘individual membership association’ and ‘IMA’
 21 mean a legal entity that meets the following requirements:

22 “(1) ORGANIZATION.—The IMA is an organiza-
 23 tion operated under the direction of an association
 24 (as defined in section 3104(1)).

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

3 “(A) DIFFERENT GROUPS.—The IMA, in
4 conjunction with those health insurance issuers
5 that offer health benefits coverage through the
6 IMA, makes available health benefits coverage
7 in the manner described in subsection (b) to all
8 members of the IMA and the dependents of
9 such members in the manner described in sub-
10 section (c)(2) at rates that are established by
11 the health insurance issuer on a policy or prod-
12 uct specific basis and that may vary only as
13 permissible under State law.

14 “(B) NONDISCRIMINATION IN COVERAGE
15 OFFERED.—

16 “(i) IN GENERAL.—Subject to clause
17 (ii), the IMA may not offer health benefits
18 coverage to a member of an IMA unless
19 the same coverage is offered to all such
20 members of the IMA.

21 “(ii) CONSTRUCTION.—Nothing in
22 this title shall be construed as requiring or
23 permitting a health insurance issuer to
24 provide coverage outside the service area of
25 the issuer, as approved under State law, or

1 requiring a health insurance issuer from
2 excluding or limiting the coverage on any
3 individual, subject to the requirement of
4 section 2741.

5 “(C) NO FINANCIAL UNDERWRITING.—The
6 IMA provides health benefits coverage only
7 through contracts with health insurance issuers
8 and does not assume insurance risk with re-
9 spect to such coverage.

10 “(3) GEOGRAPHIC AREAS.—Nothing in this title
11 shall be construed as preventing the establishment
12 and operation of more than one IMA in a geographic
13 area or as limiting the number of IMAs that may
14 operate in any area.

15 “(4) PROVISION OF ADMINISTRATIVE SERVICES
16 TO PURCHASERS.—

17 “(A) IN GENERAL.—The IMA may provide
18 administrative services for members. Such serv-
19 ices may include accounting, billing, and enroll-
20 ment information.

21 “(B) CONSTRUCTION.—Nothing in this
22 subsection shall be construed as preventing an
23 IMA from serving as an administrative service
24 organization to any entity.

1 “(5) FILING INFORMATION.—The IMA files
2 with the Secretary information that demonstrates
3 the IMA’s compliance with the applicable require-
4 ments of this title.

5 “(b) HEALTH BENEFITS COVERAGE REQUIRE-
6 MENTS.—

7 “(1) COMPLIANCE WITH CONSUMER PROTEC-
8 TION REQUIREMENTS.—Any health benefits coverage
9 offered through an IMA shall—

10 “(A) be underwritten by a health insurance
11 issuer that—

12 “(i) is licensed (or otherwise regu-
13 lated) under State law,

14 “(ii) meets all applicable State stand-
15 ards relating to consumer protection, sub-
16 ject to section 3002(b), and

17 “(B) subject to paragraph (2), be approved
18 or otherwise permitted to be offered under
19 State law.

20 “(2) EXAMPLES OF TYPES OF COVERAGE.—The
21 benefits coverage made available through an IMA
22 may include, but is not limited to, any of the fol-
23 lowing if it meets the other applicable requirements
24 of this title:

1 “(A) Coverage through a health mainte-
2 nance organization.

3 “(B) Coverage in connection with a pre-
4 ferred provider organization.

5 “(C) Coverage in connection with a li-
6 censed provider-sponsored organization.

7 “(D) Indemnity coverage through an insur-
8 ance company.

9 “(E) Coverage offered in connection with a
10 contribution into a medical savings account or
11 flexible spending account.

12 “(F) Coverage that includes a point-of-
13 service option.

14 “(G) Any combination of such types of
15 coverage.

16 “(3) WELLNESS BONUSES FOR HEALTH PRO-
17 MOTION.—Nothing in this title shall be construed as
18 precluding a health insurance issuer offering health
19 benefits coverage through an IMA from establishing
20 premium discounts or rebates for members or from
21 modifying otherwise applicable copayments or
22 deductibles in return for adherence to programs of
23 health promotion and disease prevention so long as
24 such programs are agreed to in advance by the IMA
25 and comply with all other provisions of this title and

1 do not discriminate among similarly situated mem-
2 bers.

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

4 “(1) MEMBERS.—

5 “(A) IN GENERAL.—Under rules estab-
6 lished to carry out this title, with respect to an
7 individual who is a member of an IMA, the in-
8 dividual may enroll for health benefits coverage
9 (including coverage for dependents of such indi-
10 vidual) offered by a health insurance issuer
11 through the IMA.

12 “(B) RULES FOR ENROLLMENT.—Nothing
13 in this paragraph shall preclude an IMA from
14 establishing rules of enrollment and reenroll-
15 ment of members. Such rules shall be applied
16 consistently to all members within the IMA and
17 shall not be based in any manner on health sta-
18 tus-related factors.

19 “(2) HEALTH INSURANCE ISSUERS.—The con-
20 tract between an IMA and a health insurance issuer
21 shall provide, with respect to a member enrolled with
22 health benefits coverage offered by the issuer
23 through the IMA, for the payment of the premiums
24 collected by the issuer.

1 **“SEC. 3102. APPLICATION OF CERTAIN LAWS AND REQUIRE-**
2 **MENTS.**

3 “State laws insofar as they relate to any of the fol-
4 lowing are superseded and shall not apply to health bene-
5 fits coverage made available through an IMA:

6 “(1) Benefit requirements for health benefits
7 coverage offered through an IMA, including (but not
8 limited to) requirements relating to coverage of spe-
9 cific providers, specific services or conditions, or the
10 amount, duration, or scope of benefits, but not in-
11 cluding requirements to the extent required to imple-
12 ment title XXVII or other Federal law and to the
13 extent the requirement prohibits an exclusion of a
14 specific disease from such coverage.

15 “(2) Any other requirements (including limita-
16 tions on compensation arrangements) that, directly
17 or indirectly, preclude (or have the effect of pre-
18 cluding) the offering of such coverage through an
19 IMA, if the IMA meets the requirements of this
20 title.

21 Any State law or regulation relating to the composition
22 or organization of an IMA is preempted to the extent the
23 law or regulation is inconsistent with the provisions of this
24 title.

1 **“SEC. 3103. ADMINISTRATION.**

2 “(a) IN GENERAL.—The Secretary shall administer
3 this title and is authorized to issue such regulations as
4 may be required to carry out this title. Such regulations
5 shall be subject to Congressional review under the provi-
6 sions of chapter 8 of title 5, United States Code. The Sec-
7 retary shall incorporate the process of ‘deemed file and
8 use’ with respect to the information filed under section
9 3001(a)(5)(A) and shall determine whether information
10 filed by an IMA demonstrates compliance with the applica-
11 ble requirements of this title. The Secretary shall exercise
12 authority under this title in a manner that fosters and
13 promotes the development of IMAs in order to improve
14 access to health care coverage and services.

15 “(b) PERIODIC REPORTS.—The Secretary shall sub-
16 mit to Congress a report every 30 months, during the 10-
17 year period beginning on the effective date of the rules
18 promulgated by the Secretary to carry out this title, on
19 the effectiveness of this title in promoting coverage of un-
20 insured individuals. The Secretary may provide for the
21 production of such reports through one or more contracts
22 with appropriate private entities.

23 **“SEC. 3104. DEFINITIONS.**

24 “For purposes of this title:

1 “(1) ASSOCIATION.—The term ‘association’
2 means, with respect to health insurance coverage of-
3 fered in a State, a legal entity which—

4 “(A) has been actively in existence for at
5 least 5 years;

6 “(B) has been formed and maintained in
7 good faith for purposes other than obtaining in-
8 surance;

9 “(C) does not condition membership in the
10 association on any health status-related factor
11 relating to an individual (including an employee
12 of an employer or a dependent of an employee);
13 and

14 “(D) does not make health insurance cov-
15 erage offered through the association available
16 other than in connection with a member of the
17 association.

18 “(2) DEPENDENT.—The term ‘dependent’, as
19 applied to health insurance coverage offered by a
20 health insurance issuer licensed (or otherwise regu-
21 lated) in a State, shall have the meaning applied to
22 such term with respect to such coverage under the
23 laws of the State relating to such coverage and such
24 an issuer. Such term may include the spouse and
25 children of the individual involved.

1 **SEC. 232. RULES GOVERNING ASSOCIATION HEALTH**
2 **PLANS.**

3 (a) IN GENERAL.—Subtitle B of title I of the Em-
4 ployee Retirement Income Security Act of 1974 is amend-
5 ed by adding after part 7 the following new part:

6 **“PART 8—RULES GOVERNING ASSOCIATION**
7 **HEALTH PLANS**

8 **“SEC. 801. ASSOCIATION HEALTH PLANS.**

9 “(a) IN GENERAL.—For purposes of this part, the
10 term ‘association health plan’ means a group health plan
11 whose sponsor is (or is deemed under this part to be) de-
12 scribed in subsection (b).

13 “(b) SPONSORSHIP.—The sponsor of a group health
14 plan is described in this subsection if such sponsor—

15 “(1) is organized and maintained in good faith,
16 with a constitution and bylaws specifically stating its
17 purpose and providing for periodic meetings on at
18 least an annual basis, as a bona fide trade associa-
19 tion, a bona fide industry association (including a
20 rural electric cooperative association or a rural tele-
21 phone cooperative association), a bona fide profes-
22 sional association, or a bona fide chamber of com-
23 merce (or similar bona fide business association, in-
24 cluding a corporation or similar organization that
25 operates on a cooperative basis (within the meaning
26 of section 1381 of the Internal Revenue Code of

1 1986)), for substantial purposes other than that of
2 obtaining or providing medical care;

3 “(2) is established as a permanent entity which
4 receives the active support of its members and re-
5 quires for membership payment on a periodic basis
6 of dues or payments necessary to maintain eligibility
7 for membership in the sponsor; and

8 “(3) does not condition membership, such dues
9 or payments, or coverage under the plan on the
10 basis of health status-related factors with respect to
11 the employees of its members (or affiliated mem-
12 bers), or the dependents of such employees, and does
13 not condition such dues or payments on the basis of
14 group health plan participation.

15 Any sponsor consisting of an association of entities which
16 meet the requirements of paragraphs (1), (2), and (3)
17 shall be deemed to be a sponsor described in this sub-
18 section.

19 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**
20 **PLANS.**

21 “(a) IN GENERAL.—The applicable authority shall
22 prescribe by regulation a procedure under which, subject
23 to subsection (b), the applicable authority shall certify as-
24 sociation health plans which apply for certification as
25 meeting the requirements of this part.

1 “(b) STANDARDS.—Under the procedure prescribed
2 pursuant to subsection (a), in the case of an association
3 health plan that provides at least one benefit option which
4 does not consist of health insurance coverage, the applica-
5 ble authority shall certify such plan as meeting the re-
6 quirements of this part only if the applicable authority is
7 satisfied that the applicable requirements of this part are
8 met (or, upon the date on which the plan is to commence
9 operations, will be met) with respect to the plan.

10 “(c) REQUIREMENTS APPLICABLE TO CERTIFIED
11 PLANS.—An association health plan with respect to which
12 certification under this part is in effect shall meet the ap-
13 plicable requirements of this part, effective on the date
14 of certification (or, if later, on the date on which the plan
15 is to commence operations).

16 “(d) REQUIREMENTS FOR CONTINUED CERTIFI-
17 CATION.—The applicable authority may provide by regula-
18 tion for continued certification of association health plans
19 under this part.

20 “(e) CLASS CERTIFICATION FOR FULLY INSURED
21 PLANS.—The applicable authority shall establish a class
22 certification procedure for association health plans under
23 which all benefits consist of health insurance coverage.
24 Under such procedure, the applicable authority shall pro-
25 vide for the granting of certification under this part to

1 the plans in each class of such association health plans
2 upon appropriate filing under such procedure in connec-
3 tion with plans in such class and payment of the pre-
4 scribed fee under section 807(a).

5 “(f) CERTIFICATION OF SELF-INSURED ASSOCIATION
6 HEALTH PLANS.—An association health plan which offers
7 one or more benefit options which do not consist of health
8 insurance coverage may be certified under this part only
9 if such plan consists of any of the following:

10 “(1) a plan which offered such coverage on the
11 date of the enactment of the Small Business Health
12 Fairness Act of 2011,

13 “(2) a plan under which the sponsor does not
14 restrict membership to one or more trades and busi-
15 nesses or industries and whose eligible participating
16 employers represent a broad cross-section of trades
17 and businesses or industries, or

18 “(3) a plan whose eligible participating employ-
19 ers represent one or more trades or businesses, or
20 one or more industries, consisting of any of the fol-
21 lowing: agriculture; equipment and automobile deal-
22 erships; barbering and cosmetology; certified public
23 accounting practices; child care; construction; dance,
24 theatrical and orchestra productions; disinfecting
25 and pest control; financial services; fishing; food

1 service establishments; hospitals; labor organiza-
2 tions; logging; manufacturing (metals); mining; med-
3 ical and dental practices; medical laboratories; pro-
4 fessional consulting services; sanitary services; trans-
5 portation (local and freight); warehousing; whole-
6 saling/distributing; or any other trade or business or
7 industry which has been indicated as having average
8 or above-average risk or health claims experience by
9 reason of State rate filings, denials of coverage, pro-
10 posed premium rate levels, or other means dem-
11 onstrated by such plan in accordance with regula-
12 tions.

13 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**
14 **BOARDS OF TRUSTEES.**

15 “(a) SPONSOR.—The requirements of this subsection
16 are met with respect to an association health plan if the
17 sponsor has met (or is deemed under this part to have
18 met) the requirements of section 801(b) for a continuous
19 period of not less than 3 years ending with the date of
20 the application for certification under this part.

21 “(b) BOARD OF TRUSTEES.—The requirements of
22 this subsection are met with respect to an association
23 health plan if the following requirements are met:

24 “(1) FISCAL CONTROL.—The plan is operated,
25 pursuant to a trust agreement, by a board of trust-

1 ees which has complete fiscal control over the plan
2 and which is responsible for all operations of the
3 plan.

4 “(2) RULES OF OPERATION AND FINANCIAL
5 CONTROLS.—The board of trustees has in effect
6 rules of operation and financial controls, based on a
7 3-year plan of operation, adequate to carry out the
8 terms of the plan and to meet all requirements of
9 this title applicable to the plan.

10 “(3) RULES GOVERNING RELATIONSHIP TO
11 PARTICIPATING EMPLOYERS AND TO CONTRAC-
12 TORS.—

13 “(A) BOARD MEMBERSHIP.—

14 “(i) IN GENERAL.—Except as pro-
15 vided in clauses (ii) and (iii), the members
16 of the board of trustees are individuals se-
17 lected from individuals who are the owners,
18 officers, directors, or employees of the par-
19 ticipating employers or who are partners in
20 the participating employers and actively
21 participate in the business.

22 “(ii) LIMITATION.—

23 “(I) GENERAL RULE.—Except as
24 provided in subclauses (II) and (III),
25 no such member is an owner, officer,

1 director, or employee of, or partner in,
2 a contract administrator or other
3 service provider to the plan.

4 “(II) LIMITED EXCEPTION FOR
5 PROVIDERS OF SERVICES SOLELY ON
6 BEHALF OF THE SPONSOR.—Officers
7 or employees of a sponsor which is a
8 service provider (other than a contract
9 administrator) to the plan may be
10 members of the board if they con-
11 stitute not more than 25 percent of
12 the membership of the board and they
13 do not provide services to the plan
14 other than on behalf of the sponsor.

15 “(III) TREATMENT OF PRO-
16 VIDERS OF MEDICAL CARE.—In the
17 case of a sponsor which is an associa-
18 tion whose membership consists pri-
19 marily of providers of medical care,
20 subclause (I) shall not apply in the
21 case of any service provider described
22 in subclause (I) who is a provider of
23 medical care under the plan.

24 “(iii) CERTAIN PLANS EXCLUDED.—
25 Clause (i) shall not apply to an association

1 health plan which is in existence on the
2 date of the enactment of the Small Busi-
3 ness Health Fairness Act of 2011.

4 “(B) SOLE AUTHORITY.—The board has
5 sole authority under the plan to approve appli-
6 cations for participation in the plan and to con-
7 tract with a service provider to administer the
8 day-to-day affairs of the plan.

9 “(c) TREATMENT OF FRANCHISE NETWORKS.—In
10 the case of a group health plan which is established and
11 maintained by a franchiser for a franchise network con-
12 sisting of its franchisees—

13 “(1) the requirements of subsection (a) and sec-
14 tion 801(a) shall be deemed met if such require-
15 ments would otherwise be met if the franchiser were
16 deemed to be the sponsor referred to in section
17 801(b), such network were deemed to be an associa-
18 tion described in section 801(b), and each franchisee
19 were deemed to be a member (of the association and
20 the sponsor) referred to in section 801(b); and

21 “(2) the requirements of section 804(a)(1) shall
22 be deemed met.

23 The Secretary may by regulation define for purposes of
24 this subsection the terms ‘franchiser’, ‘franchise network’,
25 and ‘franchisee’.

1 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**
2 **MENTS.**

3 “(a) COVERED EMPLOYERS AND INDIVIDUALS.—The
4 requirements of this subsection are met with respect to
5 an association health plan if, under the terms of the
6 plan—

7 “(1) each participating employer must be—

8 “(A) a member of the sponsor,

9 “(B) the sponsor, or

10 “(C) an affiliated member of the sponsor
11 with respect to which the requirements of sub-
12 section (b) are met,

13 except that, in the case of a sponsor which is a pro-
14 fessional association or other individual-based asso-
15 ciation, if at least one of the officers, directors, or
16 employees of an employer, or at least one of the in-
17 dividuals who are partners in an employer and who
18 actively participates in the business, is a member or
19 such an affiliated member of the sponsor, partici-
20 pating employers may also include such employer;
21 and

22 “(2) all individuals commencing coverage under
23 the plan after certification under this part must
24 be—

25 “(A) active or retired owners (including
26 self-employed individuals), officers, directors, or

1 employees of, or partners in, participating em-
2 ployers; or

3 “(B) the beneficiaries of individuals de-
4 scribed in subparagraph (A).

5 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-
6 PLOYEES.—In the case of an association health plan in
7 existence on the date of the enactment of the Small Busi-
8 ness Health Fairness Act of 2011, an affiliated member
9 of the sponsor of the plan may be offered coverage under
10 the plan as a participating employer only if—

11 “(1) the affiliated member was an affiliated
12 member on the date of certification under this part;
13 or

14 “(2) during the 12-month period preceding the
15 date of the offering of such coverage, the affiliated
16 member has not maintained or contributed to a
17 group health plan with respect to any of its employ-
18 ees who would otherwise be eligible to participate in
19 such association health plan.

20 “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-
21 quirements of this subsection are met with respect to an
22 association health plan if, under the terms of the plan,
23 no participating employer may provide health insurance
24 coverage in the individual market for any employee not
25 covered under the plan which is similar to the coverage

1 contemporaneously provided to employees of the employer
2 under the plan, if such exclusion of the employee from cov-
3 erage under the plan is based on a health status-related
4 factor with respect to the employee and such employee
5 would, but for such exclusion on such basis, be eligible
6 for coverage under the plan.

7 “(d) PROHIBITION OF DISCRIMINATION AGAINST
8 EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICI-
9 PATE.—The requirements of this subsection are met with
10 respect to an association health plan if—

11 “(1) under the terms of the plan, all employers
12 meeting the preceding requirements of this section
13 are eligible to qualify as participating employers for
14 all geographically available coverage options, unless,
15 in the case of any such employer, participation or
16 contribution requirements of the type referred to in
17 section 2711 of the Public Health Service Act are
18 not met;

19 “(2) upon request, any employer eligible to par-
20 ticipate is furnished information regarding all cov-
21 erage options available under the plan; and

22 “(3) the applicable requirements of sections
23 701, 702, and 703 are met with respect to the plan.

1 **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**
2 **DOCUMENTS, CONTRIBUTION RATES, AND**
3 **BENEFIT OPTIONS.**

4 “(a) IN GENERAL.—The requirements of this section
5 are met with respect to an association health plan if the
6 following requirements are met:

7 “(1) CONTENTS OF GOVERNING INSTRU-
8 MENTS.—The instruments governing the plan in-
9 clude a written instrument, meeting the require-
10 ments of an instrument required under section
11 402(a)(1), which—

12 “(A) provides that the board of trustees
13 serves as the named fiduciary required for plans
14 under section 402(a)(1) and serves in the ca-
15 pacity of a plan administrator (referred to in
16 section 3(16)(A));

17 “(B) provides that the sponsor of the plan
18 is to serve as plan sponsor (referred to in sec-
19 tion 3(16)(B)); and

20 “(C) incorporates the requirements of sec-
21 tion 806.

22 “(2) CONTRIBUTION RATES MUST BE NON-
23 DISCRIMINATORY.—

24 “(A) The contribution rates for any par-
25 ticipating small employer do not vary on the
26 basis of any health status-related factor in rela-

1 tion to employees of such employer or their
2 beneficiaries and do not vary on the basis of the
3 type of business or industry in which such em-
4 ployer is engaged.

5 “(B) Nothing in this title or any other pro-
6 vision of law shall be construed to preclude an
7 association health plan, or a health insurance
8 issuer offering health insurance coverage in
9 connection with an association health plan,
10 from—

11 “(i) setting contribution rates based
12 on the claims experience of the plan; or

13 “(ii) varying contribution rates for
14 small employers in a State to the extent
15 that such rates could vary using the same
16 methodology employed in such State for
17 regulating premium rates in the small
18 group market with respect to health insur-
19 ance coverage offered in connection with
20 bona fide associations (within the meaning
21 of section 2791(d)(3) of the Public Health
22 Service Act),

23 subject to the requirements of section 702(b)
24 relating to contribution rates.

1 “(3) FLOOR FOR NUMBER OF COVERED INDI-
2 VIDUALS WITH RESPECT TO CERTAIN PLANS.—If
3 any benefit option under the plan does not consist
4 of health insurance coverage, the plan has as of the
5 beginning of the plan year not fewer than 1,000 par-
6 ticipants and beneficiaries.

7 “(4) MARKETING REQUIREMENTS.—

8 “(A) IN GENERAL.—If a benefit option
9 which consists of health insurance coverage is
10 offered under the plan, State-licensed insurance
11 agents shall be used to distribute to small em-
12 ployers coverage which does not consist of
13 health insurance coverage in a manner com-
14 parable to the manner in which such agents are
15 used to distribute health insurance coverage.

16 “(B) STATE-LICENSED INSURANCE
17 AGENTS.—For purposes of subparagraph (A),
18 the term ‘State-licensed insurance agents’
19 means one or more agents who are licensed in
20 a State and are subject to the laws of such
21 State relating to licensure, qualification, test-
22 ing, examination, and continuing education of
23 persons authorized to offer, sell, or solicit
24 health insurance coverage in such State.

1 “(5) REGULATORY REQUIREMENTS.—Such
2 other requirements as the applicable authority deter-
3 mines are necessary to carry out the purposes of this
4 part, which shall be prescribed by the applicable au-
5 thority by regulation.

6 “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO
7 DESIGN BENEFIT OPTIONS.—Subject to section 514(d),
8 nothing in this part or any provision of State law (as de-
9 fined in section 514(c)(1)) shall be construed to preclude
10 an association health plan, or a health insurance issuer
11 offering health insurance coverage in connection with an
12 association health plan, from exercising its sole discretion
13 in selecting the specific items and services consisting of
14 medical care to be included as benefits under such plan
15 or coverage, except (subject to section 514) in the case
16 of (1) any law to the extent that it is not preempted under
17 section 731(a)(1) with respect to matters governed by sec-
18 tion 711, 712, or 713, or (2) any law of the State with
19 which filing and approval of a policy type offered by the
20 plan was initially obtained to the extent that such law pro-
21 hibits an exclusion of a specific disease from such cov-
22 erage.

1 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**
2 **FOR SOLVENCY FOR PLANS PROVIDING**
3 **HEALTH BENEFITS IN ADDITION TO HEALTH**
4 **INSURANCE COVERAGE.**

5 “(a) IN GENERAL.—The requirements of this section
6 are met with respect to an association health plan if—

7 “(1) the benefits under the plan consist solely
8 of health insurance coverage; or

9 “(2) if the plan provides any additional benefit
10 options which do not consist of health insurance cov-
11 erage, the plan—

12 “(A) establishes and maintains reserves
13 with respect to such additional benefit options,
14 in amounts recommended by the qualified
15 health actuary, consisting of—

16 “(i) a reserve sufficient for unearned
17 contributions;

18 “(ii) a reserve sufficient for benefit li-
19 abilities which have been incurred, which
20 have not been satisfied, and for which risk
21 of loss has not yet been transferred, and
22 for expected administrative costs with re-
23 spect to such benefit liabilities;

24 “(iii) a reserve sufficient for any other
25 obligations of the plan; and

1 “(iv) a reserve sufficient for a margin
2 of error and other fluctuations, taking into
3 account the specific circumstances of the
4 plan; and

5 “(B) establishes and maintains aggregate
6 and specific excess/stop loss insurance and sol-
7 vency indemnification, with respect to such ad-
8 ditional benefit options for which risk of loss
9 has not yet been transferred, as follows:

10 “(i) The plan shall secure aggregate
11 excess/stop loss insurance for the plan with
12 an attachment point which is not greater
13 than 125 percent of expected gross annual
14 claims. The applicable authority may by
15 regulation provide for upward adjustments
16 in the amount of such percentage in speci-
17 fied circumstances in which the plan spe-
18 cifically provides for and maintains re-
19 serves in excess of the amounts required
20 under subparagraph (A).

21 “(ii) The plan shall secure specific ex-
22 cess/stop loss insurance for the plan with
23 an attachment point which is at least equal
24 to an amount recommended by the plan’s
25 qualified health actuary. The applicable

1 authority may by regulation provide for ad-
2 justments in the amount of such insurance
3 in specified circumstances in which the
4 plan specifically provides for and maintains
5 reserves in excess of the amounts required
6 under subparagraph (A).

7 “(iii) The plan shall secure indem-
8 nification insurance for any claims which
9 the plan is unable to satisfy by reason of
10 a plan termination.

11 Any person issuing to a plan insurance described in clause
12 (i), (ii), or (iii) of subparagraph (B) shall notify the Sec-
13 retary of any failure of premium payment meriting can-
14 cellation of the policy prior to undertaking such a cancella-
15 tion. Any regulations prescribed by the applicable author-
16 ity pursuant to clause (i) or (ii) of subparagraph (B) may
17 allow for such adjustments in the required levels of excess/
18 stop loss insurance as the qualified health actuary may
19 recommend, taking into account the specific circumstances
20 of the plan.

21 “(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS
22 RESERVES.—In the case of any association health plan de-
23 scribed in subsection (a)(2), the requirements of this sub-
24 section are met if the plan establishes and maintains sur-
25 plus in an amount at least equal to—

1 “(1) \$500,000, or

2 “(2) such greater amount (but not greater than
3 \$2,000,000) as may be set forth in regulations pre-
4 scribed by the applicable authority, considering the
5 level of aggregate and specific excess/stop loss insur-
6 ance provided with respect to such plan and other
7 factors related to solvency risk, such as the plan’s
8 projected levels of participation or claims, the nature
9 of the plan’s liabilities, and the types of assets avail-
10 able to assure that such liabilities are met.

11 “(c) **ADDITIONAL REQUIREMENTS.**—In the case of
12 any association health plan described in subsection (a)(2),
13 the applicable authority may provide such additional re-
14 quirements relating to reserves, excess/stop loss insurance,
15 and indemnification insurance as the applicable authority
16 considers appropriate. Such requirements may be provided
17 by regulation with respect to any such plan or any class
18 of such plans.

19 “(d) **ADJUSTMENTS FOR EXCESS/STOP LOSS INSUR-**
20 **ANCE.**—The applicable authority may provide for adjust-
21 ments to the levels of reserves otherwise required under
22 subsections (a) and (b) with respect to any plan or class
23 of plans to take into account excess/stop loss insurance
24 provided with respect to such plan or plans.

1 “(e) ALTERNATIVE MEANS OF COMPLIANCE.—The
2 applicable authority may permit an association health plan
3 described in subsection (a)(2) to substitute, for all or part
4 of the requirements of this section (except subsection
5 (a)(2)(B)(iii)), such security, guarantee, hold-harmless ar-
6 rangement, or other financial arrangement as the applica-
7 ble authority determines to be adequate to enable the plan
8 to fully meet all its financial obligations on a timely basis
9 and is otherwise no less protective of the interests of par-
10 ticipants and beneficiaries than the requirements for
11 which it is substituted. The applicable authority may take
12 into account, for purposes of this subsection, evidence pro-
13 vided by the plan or sponsor which demonstrates an as-
14 sumption of liability with respect to the plan. Such evi-
15 dence may be in the form of a contract of indemnification,
16 lien, bonding, insurance, letter of credit, recourse under
17 applicable terms of the plan in the form of assessments
18 of participating employers, security, or other financial ar-
19 rangement.

20 “(f) MEASURES TO ENSURE CONTINUED PAYMENT
21 OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

22 “(1) PAYMENTS BY CERTAIN PLANS TO ASSO-
23 CIATION HEALTH PLAN FUND.—

24 “(A) IN GENERAL.—In the case of an as-
25 sociation health plan described in subsection

1 (a)(2), the requirements of this subsection are
2 met if the plan makes payments into the Asso-
3 ciation Health Plan Fund under this subpara-
4 graph when they are due. Such payments shall
5 consist of annual payments in the amount of
6 \$5,000, and, in addition to such annual pay-
7 ments, such supplemental payments as the Sec-
8 retary may determine to be necessary under
9 paragraph (2). Payments under this paragraph
10 are payable to the Fund at the time determined
11 by the Secretary. Initial payments are due in
12 advance of certification under this part. Pay-
13 ments shall continue to accrue until a plan's as-
14 sets are distributed pursuant to a termination
15 procedure.

16 “(B) PENALTIES FOR FAILURE TO MAKE
17 PAYMENTS.—If any payment is not made by a
18 plan when it is due, a late payment charge of
19 not more than 100 percent of the payment
20 which was not timely paid shall be payable by
21 the plan to the Fund.

22 “(C) CONTINUED DUTY OF THE SEC-
23 RETARY.—The Secretary shall not cease to
24 carry out the provisions of paragraph (2) on ac-

1 count of the failure of a plan to pay any pay-
2 ment when due.

3 “(2) PAYMENTS BY SECRETARY TO CONTINUE
4 EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-
5 DEMNIFICATION INSURANCE COVERAGE FOR CER-
6 TAIN PLANS.—In any case in which the applicable
7 authority determines that there is, or that there is
8 reason to believe that there will be: (A) a failure to
9 take necessary corrective actions under section
10 809(a) with respect to an association health plan de-
11 scribed in subsection (a)(2); or (B) a termination of
12 such a plan under section 809(b) or 810(b)(8) (and,
13 if the applicable authority is not the Secretary, cer-
14 tifies such determination to the Secretary), the Sec-
15 retary shall determine the amounts necessary to
16 make payments to an insurer (designated by the
17 Secretary) to maintain in force excess/stop loss in-
18 surance coverage or indemnification insurance cov-
19 erage for such plan, if the Secretary determines that
20 there is a reasonable expectation that, without such
21 payments, claims would not be satisfied by reason of
22 termination of such coverage. The Secretary shall, to
23 the extent provided in advance in appropriation
24 Acts, pay such amounts so determined to the insurer
25 designated by the Secretary.

1 “(3) ASSOCIATION HEALTH PLAN FUND.—

2 “(A) IN GENERAL.—There is established
3 on the books of the Treasury a fund to be
4 known as the ‘Association Health Plan Fund’.
5 The Fund shall be available for making pay-
6 ments pursuant to paragraph (2). The Fund
7 shall be credited with payments received pursu-
8 ant to paragraph (1)(A), penalties received pur-
9 suant to paragraph (1)(B), and earnings on in-
10 vestments of amounts of the Fund under sub-
11 paragraph (B).

12 “(B) INVESTMENT.—Whenever the Sec-
13 retary determines that the moneys of the fund
14 are in excess of current needs, the Secretary
15 may request the investment of such amounts as
16 the Secretary determines advisable by the Sec-
17 retary of the Treasury in obligations issued or
18 guaranteed by the United States.

19 “(g) EXCESS/STOP LOSS INSURANCE.—For purposes
20 of this section—

21 “(1) AGGREGATE EXCESS/STOP LOSS INSUR-
22 ANCE.—The term ‘aggregate excess/stop loss insur-
23 ance’ means, in connection with an association
24 health plan, a contract—

1 “(A) under which an insurer (meeting such
2 minimum standards as the applicable authority
3 may prescribe by regulation) provides for pay-
4 ment to the plan with respect to aggregate
5 claims under the plan in excess of an amount
6 or amounts specified in such contract;

7 “(B) which is guaranteed renewable; and

8 “(C) which allows for payment of pre-
9 miums by any third party on behalf of the in-
10 sured plan.

11 “(2) SPECIFIC EXCESS/STOP LOSS INSUR-
12 ANCE.—The term ‘specific excess/stop loss insur-
13 ance’ means, in connection with an association
14 health plan, a contract—

15 “(A) under which an insurer (meeting such
16 minimum standards as the applicable authority
17 may prescribe by regulation) provides for pay-
18 ment to the plan with respect to claims under
19 the plan in connection with a covered individual
20 in excess of an amount or amounts specified in
21 such contract in connection with such covered
22 individual;

23 “(B) which is guaranteed renewable; and

1 “(C) which allows for payment of pre-
2 miums by any third party on behalf of the in-
3 sured plan.

4 “(h) INDEMNIFICATION INSURANCE.—For purposes
5 of this section, the term ‘indemnification insurance’
6 means, in connection with an association health plan, a
7 contract—

8 “(1) under which an insurer (meeting such min-
9 imum standards as the applicable authority may pre-
10 scribe by regulation) provides for payment to the
11 plan with respect to claims under the plan which the
12 plan is unable to satisfy by reason of a termination
13 pursuant to section 809(b) (relating to mandatory
14 termination);

15 “(2) which is guaranteed renewable and
16 noncancellable for any reason (except as the applica-
17 ble authority may prescribe by regulation); and

18 “(3) which allows for payment of premiums by
19 any third party on behalf of the insured plan.

20 “(i) RESERVES.—For purposes of this section, the
21 term ‘reserves’ means, in connection with an association
22 health plan, plan assets which meet the fiduciary stand-
23 ards under part 4 and such additional requirements re-
24 garding liquidity as the applicable authority may prescribe
25 by regulation.

1 “(j) SOLVENCY STANDARDS WORKING GROUP.—

2 “(1) IN GENERAL.—Within 90 days after the
3 date of the enactment of the Small Business Health
4 Fairness Act of 2011, the applicable authority shall
5 establish a Solvency Standards Working Group. In
6 prescribing the initial regulations under this section,
7 the applicable authority shall take into account the
8 recommendations of such Working Group.

9 “(2) MEMBERSHIP.—The Working Group shall
10 consist of not more than 15 members appointed by
11 the applicable authority. The applicable authority
12 shall include among persons invited to membership
13 on the Working Group at least one of each of the
14 following:

15 “(A) A representative of the National As-
16 sociation of Insurance Commissioners.

17 “(B) A representative of the American
18 Academy of Actuaries.

19 “(C) A representative of the State govern-
20 ments, or their interests.

21 “(D) A representative of existing self-in-
22 sured arrangements, or their interests.

23 “(E) A representative of associations of
24 the type referred to in section 801(b)(1), or
25 their interests.

1 “(F) A representative of multiemployer
2 plans that are group health plans, or their in-
3 terests.

4 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**
5 **LATED REQUIREMENTS.**

6 “(a) FILING FEE.—Under the procedure prescribed
7 pursuant to section 802(a), an association health plan
8 shall pay to the applicable authority at the time of filing
9 an application for certification under this part a filing fee
10 in the amount of \$5,000, which shall be available in the
11 case of the Secretary, to the extent provided in appropria-
12 tion Acts, for the sole purpose of administering the certifi-
13 cation procedures applicable with respect to association
14 health plans.

15 “(b) INFORMATION TO BE INCLUDED IN APPLICA-
16 TION FOR CERTIFICATION.—An application for certifi-
17 cation under this part meets the requirements of this sec-
18 tion only if it includes, in a manner and form which shall
19 be prescribed by the applicable authority by regulation, at
20 least the following information:

21 “(1) IDENTIFYING INFORMATION.—The names
22 and addresses of—

23 “(A) the sponsor; and

24 “(B) the members of the board of trustees
25 of the plan.

1 “(2) STATES IN WHICH PLAN INTENDS TO DO
2 BUSINESS.—The States in which participants and
3 beneficiaries under the plan are to be located and
4 the number of them expected to be located in each
5 such State.

6 “(3) BONDING REQUIREMENTS.—Evidence pro-
7 vided by the board of trustees that the bonding re-
8 quirements of section 412 will be met as of the date
9 of the application or (if later) commencement of op-
10 erations.

11 “(4) PLAN DOCUMENTS.—A copy of the docu-
12 ments governing the plan (including any bylaws and
13 trust agreements), the summary plan description,
14 and other material describing the benefits that will
15 be provided to participants and beneficiaries under
16 the plan.

17 “(5) AGREEMENTS WITH SERVICE PRO-
18 VIDERS.—A copy of any agreements between the
19 plan and contract administrators and other service
20 providers.

21 “(6) FUNDING REPORT.—In the case of asso-
22 ciation health plans providing benefits options in ad-
23 dition to health insurance coverage, a report setting
24 forth information with respect to such additional
25 benefit options determined as of a date within the

1 120-day period ending with the date of the applica-
2 tion, including the following:

3 “(A) RESERVES.—A statement, certified
4 by the board of trustees of the plan, and a
5 statement of actuarial opinion, signed by a
6 qualified health actuary, that all applicable re-
7 quirements of section 806 are or will be met in
8 accordance with regulations which the applica-
9 ble authority shall prescribe.

10 “(B) ADEQUACY OF CONTRIBUTION
11 RATES.—A statement of actuarial opinion,
12 signed by a qualified health actuary, which sets
13 forth a description of the extent to which con-
14 tribution rates are adequate to provide for the
15 payment of all obligations and the maintenance
16 of required reserves under the plan for the 12-
17 month period beginning with such date within
18 such 120-day period, taking into account the
19 expected coverage and experience of the plan. If
20 the contribution rates are not fully adequate,
21 the statement of actuarial opinion shall indicate
22 the extent to which the rates are inadequate
23 and the changes needed to ensure adequacy.

24 “(C) CURRENT AND PROJECTED VALUE OF
25 ASSETS AND LIABILITIES.—A statement of ac-

1 tuarial opinion signed by a qualified health ac-
2 tuary, which sets forth the current value of the
3 assets and liabilities accumulated under the
4 plan and a projection of the assets, liabilities,
5 income, and expenses of the plan for the 12-
6 month period referred to in subparagraph (B).
7 The income statement shall identify separately
8 the plan’s administrative expenses and claims.

9 “(D) COSTS OF COVERAGE TO BE
10 CHARGED AND OTHER EXPENSES.—A state-
11 ment of the costs of coverage to be charged, in-
12 cluding an itemization of amounts for adminis-
13 tration, reserves, and other expenses associated
14 with the operation of the plan.

15 “(E) OTHER INFORMATION.—Any other
16 information as may be determined by the appli-
17 cable authority, by regulation, as necessary to
18 carry out the purposes of this part.

19 “(c) FILING NOTICE OF CERTIFICATION WITH
20 STATES.—A certification granted under this part to an
21 association health plan shall not be effective unless written
22 notice of such certification is filed with the applicable
23 State authority of each State in which at least 25 percent
24 of the participants and beneficiaries under the plan are
25 located. For purposes of this subsection, an individual

1 shall be considered to be located in the State in which a
2 known address of such individual is located or in which
3 such individual is employed.

4 “(d) NOTICE OF MATERIAL CHANGES.—In the case
5 of any association health plan certified under this part,
6 descriptions of material changes in any information which
7 was required to be submitted with the application for the
8 certification under this part shall be filed in such form
9 and manner as shall be prescribed by the applicable au-
10 thority by regulation. The applicable authority may re-
11 quire by regulation prior notice of material changes with
12 respect to specified matters which might serve as the basis
13 for suspension or revocation of the certification.

14 “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-
15 SOCIATION HEALTH PLANS.—An association health plan
16 certified under this part which provides benefit options in
17 addition to health insurance coverage for such plan year
18 shall meet the requirements of section 103 by filing an
19 annual report under such section which shall include infor-
20 mation described in subsection (b)(6) with respect to the
21 plan year and, notwithstanding section 104(a)(1)(A), shall
22 be filed with the applicable authority not later than 90
23 days after the close of the plan year (or on such later date
24 as may be prescribed by the applicable authority). The ap-

1 plicable authority may require by regulation such interim
2 reports as it considers appropriate.

3 “(f) ENGAGEMENT OF QUALIFIED HEALTH ACTU-
4 ARY.—The board of trustees of each association health
5 plan which provides benefits options in addition to health
6 insurance coverage and which is applying for certification
7 under this part or is certified under this part shall engage,
8 on behalf of all participants and beneficiaries, a qualified
9 health actuary who shall be responsible for the preparation
10 of the materials comprising information necessary to be
11 submitted by a qualified health actuary under this part.
12 The qualified health actuary shall utilize such assumptions
13 and techniques as are necessary to enable such actuary
14 to form an opinion as to whether the contents of the mat-
15 ters reported under this part—

16 “(1) are in the aggregate reasonably related to
17 the experience of the plan and to reasonable expecta-
18 tions; and

19 “(2) represent such actuary’s best estimate of
20 anticipated experience under the plan.

21 The opinion by the qualified health actuary shall be made
22 with respect to, and shall be made a part of, the annual
23 report.

1 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**
2 **MINATION.**

3 “Except as provided in section 809(b), an association
4 health plan which is or has been certified under this part
5 may terminate (upon or at any time after cessation of ac-
6 cruals in benefit liabilities) only if the board of trustees,
7 not less than 60 days before the proposed termination
8 date—

9 “(1) provides to the participants and bene-
10 ficiaries a written notice of intent to terminate stat-
11 ing that such termination is intended and the pro-
12 posed termination date;

13 “(2) develops a plan for winding up the affairs
14 of the plan in connection with such termination in
15 a manner which will result in timely payment of all
16 benefits for which the plan is obligated; and

17 “(3) submits such plan in writing to the appli-
18 cable authority.

19 Actions required under this section shall be taken in such
20 form and manner as may be prescribed by the applicable
21 authority by regulation.

22 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**
23 **NATION.**

24 “(a) ACTIONS TO AVOID DEPLETION OF RE-
25 SERVES.—An association health plan which is certified
26 under this part and which provides benefits other than

1 health insurance coverage shall continue to meet the re-
2 quirements of section 806, irrespective of whether such
3 certification continues in effect. The board of trustees of
4 such plan shall determine quarterly whether the require-
5 ments of section 806 are met. In any case in which the
6 board determines that there is reason to believe that there
7 is or will be a failure to meet such requirements, or the
8 applicable authority makes such a determination and so
9 notifies the board, the board shall immediately notify the
10 qualified health actuary engaged by the plan, and such
11 actuary shall, not later than the end of the next following
12 month, make such recommendations to the board for cor-
13 rective action as the actuary determines necessary to en-
14 sure compliance with section 806. Not later than 30 days
15 after receiving from the actuary recommendations for cor-
16 rective actions, the board shall notify the applicable au-
17 thority (in such form and manner as the applicable au-
18 thority may prescribe by regulation) of such recommenda-
19 tions of the actuary for corrective action, together with
20 a description of the actions (if any) that the board has
21 taken or plans to take in response to such recommenda-
22 tions. The board shall thereafter report to the applicable
23 authority, in such form and frequency as the applicable
24 authority may specify to the board, regarding corrective

1 action taken by the board until the requirements of section
2 806 are met.

3 “(b) MANDATORY TERMINATION.—In any case in
4 which—

5 “(1) the applicable authority has been notified
6 under subsection (a) (or by an issuer of excess/stop
7 loss insurance or indemnity insurance pursuant to
8 section 806(a)) of a failure of an association health
9 plan which is or has been certified under this part
10 and is described in section 806(a)(2) to meet the re-
11 quirements of section 806 and has not been notified
12 by the board of trustees of the plan that corrective
13 action has restored compliance with such require-
14 ments; and

15 “(2) the applicable authority determines that
16 there is a reasonable expectation that the plan will
17 continue to fail to meet the requirements of section
18 806,

19 the board of trustees of the plan shall, at the direction
20 of the applicable authority, terminate the plan and, in the
21 course of the termination, take such actions as the appli-
22 cable authority may require, including satisfying any
23 claims referred to in section 806(a)(2)(B)(iii) and recov-
24 ering for the plan any liability under subsection
25 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure

1 that the affairs of the plan will be, to the maximum extent
2 possible, wound up in a manner which will result in timely
3 provision of all benefits for which the plan is obligated.

4 **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**
5 **VENT ASSOCIATION HEALTH PLANS PRO-**
6 **VIDING HEALTH BENEFITS IN ADDITION TO**
7 **HEALTH INSURANCE COVERAGE.**

8 “(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR
9 INSOLVENT PLANS.—Whenever the Secretary determines
10 that an association health plan which is or has been cer-
11 tified under this part and which is described in section
12 806(a)(2) will be unable to provide benefits when due or
13 is otherwise in a financially hazardous condition, as shall
14 be defined by the Secretary by regulation, the Secretary
15 shall, upon notice to the plan, apply to the appropriate
16 United States district court for appointment of the Sec-
17 retary as trustee to administer the plan for the duration
18 of the insolvency. The plan may appear as a party and
19 other interested persons may intervene in the proceedings
20 at the discretion of the court. The court shall appoint such
21 Secretary trustee if the court determines that the trustee-
22 ship is necessary to protect the interests of the partici-
23 pants and beneficiaries or providers of medical care or to
24 avoid any unreasonable deterioration of the financial con-
25 dition of the plan. The trusteeship of such Secretary shall

1 continue until the conditions described in the first sen-
2 tence of this subsection are remedied or the plan is termi-
3 nated.

4 “(b) POWERS AS TRUSTEE.—The Secretary, upon
5 appointment as trustee under subsection (a), shall have
6 the power—

7 “(1) to do any act authorized by the plan, this
8 title, or other applicable provisions of law to be done
9 by the plan administrator or any trustee of the plan;

10 “(2) to require the transfer of all (or any part)
11 of the assets and records of the plan to the Sec-
12 retary as trustee;

13 “(3) to invest any assets of the plan which the
14 Secretary holds in accordance with the provisions of
15 the plan, regulations prescribed by the Secretary,
16 and applicable provisions of law;

17 “(4) to require the sponsor, the plan adminis-
18 trator, any participating employer, and any employee
19 organization representing plan participants to fur-
20 nish any information with respect to the plan which
21 the Secretary as trustee may reasonably need in
22 order to administer the plan;

23 “(5) to collect for the plan any amounts due the
24 plan and to recover reasonable expenses of the trust-
25 eeship;

1 “(6) to commence, prosecute, or defend on be-
2 half of the plan any suit or proceeding involving the
3 plan;

4 “(7) to issue, publish, or file such notices, state-
5 ments, and reports as may be required by the Sec-
6 retary by regulation or required by any order of the
7 court;

8 “(8) to terminate the plan (or provide for its
9 termination in accordance with section 809(b)) and
10 liquidate the plan assets, to restore the plan to the
11 responsibility of the sponsor, or to continue the
12 trusteeship;

13 “(9) to provide for the enrollment of plan par-
14 ticipants and beneficiaries under appropriate cov-
15 erage options; and

16 “(10) to do such other acts as may be nec-
17 essary to comply with this title or any order of the
18 court and to protect the interests of plan partici-
19 pants and beneficiaries and providers of medical
20 care.

21 “(c) NOTICE OF APPOINTMENT.—As soon as prac-
22 ticable after the Secretary’s appointment as trustee, the
23 Secretary shall give notice of such appointment to—

24 “(1) the sponsor and plan administrator;

25 “(2) each participant;

1 “(3) each participating employer; and

2 “(4) if applicable, each employee organization
3 which, for purposes of collective bargaining, rep-
4 resents plan participants.

5 “(d) ADDITIONAL DUTIES.—Except to the extent in-
6 consistent with the provisions of this title, or as may be
7 otherwise ordered by the court, the Secretary, upon ap-
8 pointment as trustee under this section, shall be subject
9 to the same duties as those of a trustee under section 704
10 of title 11, United States Code, and shall have the duties
11 of a fiduciary for purposes of this title.

12 “(e) OTHER PROCEEDINGS.—An application by the
13 Secretary under this subsection may be filed notwith-
14 standing the pendency in the same or any other court of
15 any bankruptcy, mortgage foreclosure, or equity receiver-
16 ship proceeding, or any proceeding to reorganize, conserve,
17 or liquidate such plan or its property, or any proceeding
18 to enforce a lien against property of the plan.

19 “(f) JURISDICTION OF COURT.—

20 “(1) IN GENERAL.—Upon the filing of an appli-
21 cation for the appointment as trustee or the issuance
22 of a decree under this section, the court to which the
23 application is made shall have exclusive jurisdiction
24 of the plan involved and its property wherever lo-
25 cated with the powers, to the extent consistent with

1 the purposes of this section, of a court of the United
2 States having jurisdiction over cases under chapter
3 11 of title 11, United States Code. Pending an adju-
4 dication under this section such court shall stay, and
5 upon appointment by it of the Secretary as trustee,
6 such court shall continue the stay of, any pending
7 mortgage foreclosure, equity receivership, or other
8 proceeding to reorganize, conserve, or liquidate the
9 plan, the sponsor, or property of such plan or spon-
10 sor, and any other suit against any receiver, conser-
11 vator, or trustee of the plan, the sponsor, or prop-
12 erty of the plan or sponsor. Pending such adjudica-
13 tion and upon the appointment by it of the Sec-
14 retary as trustee, the court may stay any proceeding
15 to enforce a lien against property of the plan or the
16 sponsor or any other suit against the plan or the
17 sponsor.

18 “(2) VENUE.—An action under this section
19 may be brought in the judicial district where the
20 sponsor or the plan administrator resides or does
21 business or where any asset of the plan is situated.
22 A district court in which such action is brought may
23 issue process with respect to such action in any
24 other judicial district.

1 “(g) PERSONNEL.—In accordance with regulations
2 which shall be prescribed by the Secretary, the Secretary
3 shall appoint, retain, and compensate accountants, actu-
4 aries, and other professional service personnel as may be
5 necessary in connection with the Secretary’s service as
6 trustee under this section.

7 **“SEC. 811. STATE ASSESSMENT AUTHORITY.**

8 “(a) IN GENERAL.—Notwithstanding section 514, a
9 State may impose by law a contribution tax on an associa-
10 tion health plan described in section 806(a)(2), if the plan
11 commenced operations in such State after the date of the
12 enactment of the Small Business Health Fairness Act of
13 2011.

14 “(b) CONTRIBUTION TAX.—For purposes of this sec-
15 tion, the term ‘contribution tax’ imposed by a State on
16 an association health plan means any tax imposed by such
17 State if—

18 “(1) such tax is computed by applying a rate to
19 the amount of premiums or contributions, with re-
20 spect to individuals covered under the plan who are
21 residents of such State, which are received by the
22 plan from participating employers located in such
23 State or from such individuals;

24 “(2) the rate of such tax does not exceed the
25 rate of any tax imposed by such State on premiums

1 or contributions received by insurers or health main-
2 tenance organizations for health insurance coverage
3 offered in such State in connection with a group
4 health plan;

5 “(3) such tax is otherwise nondiscriminatory;
6 and

7 “(4) the amount of any such tax assessed on
8 the plan is reduced by the amount of any tax or as-
9 sessment otherwise imposed by the State on pre-
10 miums, contributions, or both received by insurers or
11 health maintenance organizations for health insur-
12 ance coverage, aggregate excess/stop loss insurance
13 (as defined in section 806(g)(1)), specific excess/stop
14 loss insurance (as defined in section 806(g)(2)),
15 other insurance related to the provision of medical
16 care under the plan, or any combination thereof pro-
17 vided by such insurers or health maintenance organi-
18 zations in such State in connection with such plan.

19 **“SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.**

20 “(a) DEFINITIONS.—For purposes of this part—

21 “(1) GROUP HEALTH PLAN.—The term ‘group
22 health plan’ has the meaning provided in section
23 733(a)(1) (after applying subsection (b) of this sec-
24 tion).

1 “(2) MEDICAL CARE.—The term ‘medical care’
2 has the meaning provided in section 733(a)(2).

3 “(3) HEALTH INSURANCE COVERAGE.—The
4 term ‘health insurance coverage’ has the meaning
5 provided in section 733(b)(1).

6 “(4) HEALTH INSURANCE ISSUER.—The term
7 ‘health insurance issuer’ has the meaning provided
8 in section 733(b)(2).

9 “(5) APPLICABLE AUTHORITY.—The term ‘ap-
10 plicable authority’ means the Secretary, except that,
11 in connection with any exercise of the Secretary’s
12 authority regarding which the Secretary is required
13 under section 506(d) to consult with a State, such
14 term means the Secretary, in consultation with such
15 State.

16 “(6) HEALTH STATUS-RELATED FACTOR.—The
17 term ‘health status-related factor’ has the meaning
18 provided in section 733(d)(2).

19 “(7) INDIVIDUAL MARKET.—

20 “(A) IN GENERAL.—The term ‘individual
21 market’ means the market for health insurance
22 coverage offered to individuals other than in
23 connection with a group health plan.

24 “(B) TREATMENT OF VERY SMALL
25 GROUPS.—

1 “(i) IN GENERAL.—Subject to clause
2 (ii), such term includes coverage offered in
3 connection with a group health plan that
4 has fewer than 2 participants as current
5 employees or participants described in sec-
6 tion 732(d)(3) on the first day of the plan
7 year.

8 “(ii) STATE EXCEPTION.—Clause (i)
9 shall not apply in the case of health insur-
10 ance coverage offered in a State if such
11 State regulates the coverage described in
12 such clause in the same manner and to the
13 same extent as coverage in the small group
14 market (as defined in section 2791(e)(5) of
15 the Public Health Service Act) is regulated
16 by such State.

17 “(8) PARTICIPATING EMPLOYER.—The term
18 ‘participating employer’ means, in connection with
19 an association health plan, any employer, if any indi-
20 vidual who is an employee of such employer, a part-
21 ner in such employer, or a self-employed individual
22 who is such employer (or any dependent, as defined
23 under the terms of the plan, of such individual) is
24 or was covered under such plan in connection with
25 the status of such individual as such an employee,

1 partner, or self-employed individual in relation to the
2 plan.

3 “(9) APPLICABLE STATE AUTHORITY.—The
4 term ‘applicable State authority’ means, with respect
5 to a health insurance issuer in a State, the State in-
6 surance commissioner or official or officials des-
7 ignated by the State to enforce the requirements of
8 title XXVII of the Public Health Service Act for the
9 State involved with respect to such issuer.

10 “(10) QUALIFIED HEALTH ACTUARY.—The
11 term ‘qualified health actuary’ means an individual
12 who is a member of the American Academy of Actu-
13 aries with expertise in health care.

14 “(11) AFFILIATED MEMBER.—The term ‘affili-
15 ated member’ means, in connection with a sponsor—

16 “(A) a person who is otherwise eligible to
17 be a member of the sponsor but who elects an
18 affiliated status with the sponsor,

19 “(B) in the case of a sponsor with mem-
20 bers which consist of associations, a person who
21 is a member of any such association and elects
22 an affiliated status with the sponsor, or

23 “(C) in the case of an association health
24 plan in existence on the date of the enactment
25 of the Small Business Health Fairness Act of

1 2011, a person eligible to be a member of the
2 sponsor or one of its member associations.

3 “(12) LARGE EMPLOYER.—The term ‘large em-
4 ployer’ means, in connection with a group health
5 plan with respect to a plan year, an employer who
6 employed an average of at least 51 employees on
7 business days during the preceding calendar year
8 and who employs at least 2 employees on the first
9 day of the plan year.

10 “(13) SMALL EMPLOYER.—The term ‘small em-
11 ployer’ means, in connection with a group health
12 plan with respect to a plan year, an employer who
13 is not a large employer.

14 “(b) RULES OF CONSTRUCTION.—

15 “(1) EMPLOYERS AND EMPLOYEES.—For pur-
16 poses of determining whether a plan, fund, or pro-
17 gram is an employee welfare benefit plan which is an
18 association health plan, and for purposes of applying
19 this title in connection with such plan, fund, or pro-
20 gram so determined to be such an employee welfare
21 benefit plan—

22 “(A) in the case of a partnership, the term
23 ‘employer’ (as defined in section 3(5)) includes
24 the partnership in relation to the partners, and
25 the term ‘employee’ (as defined in section 3(6))

1 includes any partner in relation to the partner-
2 ship; and

3 “(B) in the case of a self-employed indi-
4 vidual, the term ‘employer’ (as defined in sec-
5 tion 3(5)) and the term ‘employee’ (as defined
6 in section 3(6)) shall include such individual.

7 “(2) PLANS, FUNDS, AND PROGRAMS TREATED
8 AS EMPLOYEE WELFARE BENEFIT PLANS.—In the
9 case of any plan, fund, or program which was estab-
10 lished or is maintained for the purpose of providing
11 medical care (through the purchase of insurance or
12 otherwise) for employees (or their dependents) cov-
13 ered thereunder and which demonstrates to the Sec-
14 retary that all requirements for certification under
15 this part would be met with respect to such plan,
16 fund, or program if such plan, fund, or program
17 were a group health plan, such plan, fund, or pro-
18 gram shall be treated for purposes of this title as an
19 employee welfare benefit plan on and after the date
20 of such demonstration.

21 “(3) EXCEPTION FOR CERTAIN BENEFITS.—
22 The requirements of this part shall not apply to a
23 group health plan in relation to its provision of ex-
24 cepted benefits, as defined in section 706(c).”.

1 (b) CONFORMING AMENDMENTS TO PREEMPTION
2 RULES.—

3 (1) Section 514(b)(6) of such Act (29 U.S.C.
4 1144(b)(6)) is amended by adding at the end the
5 following new subparagraph:

6 “(E) The preceding subparagraphs of this paragraph
7 do not apply with respect to any State law in the case
8 of an association health plan which is certified under part
9 8.”.

10 (2) Section 514 of such Act (29 U.S.C. 1144)
11 is amended—

12 (A) in subsection (b)(4), by striking “Sub-
13 section (a)” and inserting “Subsections (a) and
14 (d)”;

15 (B) in subsection (b)(5), by striking “sub-
16 section (a)” in subparagraph (A) and inserting
17 “subsection (a) of this section and subsections
18 (a)(2)(B) and (b) of section 805”, and by strik-
19 ing “subsection (a)” in subparagraph (B) and
20 inserting “subsection (a) of this section or sub-
21 section (a)(2)(B) or (b) of section 805”;

22 (C) by redesignating subsection (d) as sub-
23 section (e); and

24 (D) by inserting after subsection (c) the
25 following new subsection:

1 “(d)(1) Except as provided in subsection (b)(4), the
2 provisions of this title shall supersede any and all State
3 laws insofar as they may now or hereafter preclude, or
4 have the effect of precluding, a health insurance issuer
5 from offering health insurance coverage in connection with
6 an association health plan which is certified under part
7 8.

8 “(2) Except as provided in paragraphs (4) and (5)
9 of subsection (b) of this section—

10 “(A) In any case in which health insurance cov-
11 erage of any policy type is offered under an associa-
12 tion health plan certified under part 8 to a partici-
13 pating employer operating in such State, the provi-
14 sions of this title shall supersede any and all laws
15 of such State insofar as they may preclude a health
16 insurance issuer from offering health insurance cov-
17 erage of the same policy type to other employers op-
18 erating in the State which are eligible for coverage
19 under such association health plan, whether or not
20 such other employers are participating employers in
21 such plan.

22 “(B) In any case in which health insurance cov-
23 erage of any policy type is offered in a State under
24 an association health plan certified under part 8 and
25 the filing, with the applicable State authority (as de-

1 fined in section 812(a)(9)), of the policy form in
2 connection with such policy type is approved by such
3 State authority, the provisions of this title shall su-
4 percede any and all laws of any other State in which
5 health insurance coverage of such type is offered, in-
6 sofar as they may preclude, upon the filing in the
7 same form and manner of such policy form with the
8 applicable State authority in such other State, the
9 approval of the filing in such other State.

10 “(3) Nothing in subsection (b)(6)(E) or the preceding
11 provisions of this subsection shall be construed, with re-
12 spect to health insurance issuers or health insurance cov-
13 erage, to supersede or impair the law of any State—

14 “(A) providing solvency standards or similar
15 standards regarding the adequacy of insurer capital,
16 surplus, reserves, or contributions, or

17 “(B) relating to prompt payment of claims.

18 “(4) For additional provisions relating to association
19 health plans, see subsections (a)(2)(B) and (b) of section
20 805.

21 “(5) For purposes of this subsection, the term ‘asso-
22 ciation health plan’ has the meaning provided in section
23 801(a), and the terms ‘health insurance coverage’, ‘par-
24 ticipating employer’, and ‘health insurance issuer’ have

1 the meanings provided such terms in section 812, respec-
2 tively.”.

3 (3) Section 514(b)(6)(A) of such Act (29
4 U.S.C. 1144(b)(6)(A)) is amended—

5 (A) in clause (i)(II), by striking “and” at
6 the end;

7 (B) in clause (ii), by inserting “and which
8 does not provide medical care (within the mean-
9 ing of section 733(a)(2)),” after “arrange-
10 ment,” and by striking “title.” and inserting
11 “title, and”; and

12 (C) by adding at the end the following new
13 clause:

14 “(iii) subject to subparagraph (E), in the case
15 of any other employee welfare benefit plan which is
16 a multiple employer welfare arrangement and which
17 provides medical care (within the meaning of section
18 733(a)(2)), any law of any State which regulates in-
19 surance may apply.”.

20 (4) Section 514(e) of such Act (as redesignated
21 by paragraph (2)(C)) is amended—

22 (A) by striking “Nothing” and inserting
23 “(1) Except as provided in paragraph (2), noth-
24 ing”; and

1 (B) by adding at the end the following new
2 paragraph:

3 “(2) Nothing in any other provision of law enacted
4 on or after the date of the enactment of the Small Busi-
5 ness Health Fairness Act of 2011 shall be construed to
6 alter, amend, modify, invalidate, impair, or supersede any
7 provision of this title, except by specific cross-reference to
8 the affected section.”.

9 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act
10 (29 U.S.C. 102(16)(B)) is amended by adding at the end
11 the following new sentence: “Such term also includes a
12 person serving as the sponsor of an association health plan
13 under part 8.”.

14 (d) DISCLOSURE OF SOLVENCY PROTECTIONS RE-
15 LATED TO SELF-INSURED AND FULLY INSURED OPTIONS
16 UNDER ASSOCIATION HEALTH PLANS.—Section 102(b)
17 of such Act (29 U.S.C. 102(b)) is amended by adding at
18 the end the following: “An association health plan shall
19 include in its summary plan description, in connection
20 with each benefit option, a description of the form of sol-
21 vency or guarantee fund protection secured pursuant to
22 this Act or applicable State law, if any.”.

23 (e) SAVINGS CLAUSE.—Section 731(c) of such Act is
24 amended by inserting “or part 8” after “this part”.

1 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-
 2 CATION OF SELF-INSURED ASSOCIATION HEALTH
 3 PLANS.—Not later than January 1, 2014, the Secretary
 4 of Labor shall report to the Committee on Education and
 5 the Workforce of the House of Representatives and the
 6 Committee on Health, Education, Labor, and Pensions of
 7 the Senate the effect association health plans have had,
 8 if any, on reducing the number of uninsured individuals.

9 (g) CLERICAL AMENDMENT.—The table of contents
 10 in section 1 of the Employee Retirement Income Security
 11 Act of 1974 is amended by inserting after the item relat-
 12 ing to section 734 the following new items:

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

- “801. Association health plans.
- “802. Certification of association health plans.
- “803. Requirements relating to sponsors and boards of trustees.
- “804. Participation and coverage requirements.
- “805. Other requirements relating to plan documents, contribution rates, and benefit options.
- “806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
- “807. Requirements for application and related requirements.
- “808. Notice requirements for voluntary termination.
- “809. Corrective actions and mandatory termination.
- “810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
- “811. State assessment authority.
- “812. Definitions and rules of construction.”.

13 **SEC. 233. CLARIFICATION OF TREATMENT OF SINGLE EM-**
 14 **PLOYER ARRANGEMENTS.**

15 Section 3(40)(B) of the Employee Retirement Income
 16 Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amend-
 17 ed—

1 (1) in clause (i), by inserting after “control
2 group,” the following: “except that, in any case in
3 which the benefit referred to in subparagraph (A)
4 consists of medical care (as defined in section
5 812(a)(2)), two or more trades or businesses, wheth-
6 er or not incorporated, shall be deemed a single em-
7 ployer for any plan year of such plan, or any fiscal
8 year of such other arrangement, if such trades or
9 businesses are within the same control group during
10 such year or at any time during the preceding 1-year
11 period,”;

12 (2) in clause (iii), by striking “(iii) the deter-
13 mination” and inserting the following:

14 “(iii)(I) in any case in which the benefit re-
15 ferred to in subparagraph (A) consists of medical
16 care (as defined in section 812(a)(2)), the deter-
17 mination of whether a trade or business is under
18 ‘common control’ with another trade or business
19 shall be determined under regulations of the Sec-
20 retary applying principles consistent and coextensive
21 with the principles applied in determining whether
22 employees of two or more trades or businesses are
23 treated as employed by a single employer under sec-
24 tion 4001(b), except that, for purposes of this para-
25 graph, an interest of greater than 25 percent may

1 not be required as the minimum interest necessary
2 for common control, or

3 “(II) in any other case, the determination”;

4 (3) by redesignating clauses (iv) and (v) as
5 clauses (v) and (vi), respectively; and

6 (4) by inserting after clause (iii) the following
7 new clause:

8 “(iv) in any case in which the benefit referred
9 to in subparagraph (A) consists of medical care (as
10 defined in section 812(a)(2)), in determining, after
11 the application of clause (i), whether benefits are
12 provided to employees of two or more employers, the
13 arrangement shall be treated as having only one par-
14 ticipating employer if, after the application of clause
15 (i), the number of individuals who are employees and
16 former employees of any one participating employer
17 and who are covered under the arrangement is
18 greater than 75 percent of the aggregate number of
19 all individuals who are employees or former employ-
20 ees of participating employers and who are covered
21 under the arrangement,”.

22 **SEC. 234. ENFORCEMENT PROVISIONS RELATING TO ASSO-**
23 **CIATION HEALTH PLANS.**

24 (a) **CRIMINAL PENALTIES FOR CERTAIN WILLFUL**
25 **MISREPRESENTATIONS.**—Section 501 of the Employee

1 Retirement Income Security Act of 1974 (29 U.S.C. 1131)

2 is amended—

3 (1) by inserting “(a)” after “Sec. 501.”; and

4 (2) by adding at the end the following new sub-
5 section:

6 “(b) Any person who willfully falsely represents, to
7 any employee, any employee’s beneficiary, any employer,
8 the Secretary, or any State, a plan or other arrangement
9 established or maintained for the purpose of offering or
10 providing any benefit described in section 3(1) to employ-
11 ees or their beneficiaries as—

12 “(1) being an association health plan which has
13 been certified under part 8;

14 “(2) having been established or maintained
15 under or pursuant to one or more collective bar-
16 gaining agreements which are reached pursuant to
17 collective bargaining described in section 8(d) of the
18 National Labor Relations Act (29 U.S.C. 158(d)) or
19 paragraph Fourth of section 2 of the Railway Labor
20 Act (45 U.S.C. 152, paragraph Fourth) or which are
21 reached pursuant to labor-management negotiations
22 under similar provisions of State public employee re-
23 lations laws; or

24 “(3) being a plan or arrangement described in
25 section 3(40)(A)(i),

1 shall, upon conviction, be imprisoned not more than 5
2 years, be fined under title 18, United States Code, or
3 both.”.

4 (b) CEASE ACTIVITIES ORDERS.—Section 502 of
5 such Act (29 U.S.C. 1132) is amended by adding at the
6 end the following new subsection:

7 “(n) ASSOCIATION HEALTH PLAN CEASE AND DE-
8 SIST ORDERS.—

9 “(1) IN GENERAL.—Subject to paragraph (2),
10 upon application by the Secretary showing the oper-
11 ation, promotion, or marketing of an association
12 health plan (or similar arrangement providing bene-
13 fits consisting of medical care (as defined in section
14 733(a)(2))) that—

15 “(A) is not certified under part 8, is sub-
16 ject under section 514(b)(6) to the insurance
17 laws of any State in which the plan or arrange-
18 ment offers or provides benefits, and is not li-
19 censed, registered, or otherwise approved under
20 the insurance laws of such State; or

21 “(B) is an association health plan certified
22 under part 8 and is not operating in accordance
23 with the requirements under part 8 for such
24 certification,

1 a district court of the United States shall enter an
2 order requiring that the plan or arrangement cease
3 activities.

4 “(2) EXCEPTION.—Paragraph (1) shall not
5 apply in the case of an association health plan or
6 other arrangement if the plan or arrangement shows
7 that—

8 “(A) all benefits under it referred to in
9 paragraph (1) consist of health insurance cov-
10 erage; and

11 “(B) with respect to each State in which
12 the plan or arrangement offers or provides ben-
13 efits, the plan or arrangement is operating in
14 accordance with applicable State laws that are
15 not superseded under section 514.

16 “(3) ADDITIONAL EQUITABLE RELIEF.—The
17 court may grant such additional equitable relief, in-
18 cluding any relief available under this title, as it
19 deems necessary to protect the interests of the pub-
20 lic and of persons having claims for benefits against
21 the plan.”.

22 (c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—
23 Section 503 of such Act (29 U.S.C. 1133) is amended by
24 inserting “(a) IN GENERAL.—” before “In accordance”,
25 and by adding at the end the following new subsection:

1 “(2) RECOGNITION OF PRIMARY DOMICILE
2 STATE.—In carrying out paragraph (1), the Sec-
3 retary shall ensure that only one State will be recog-
4 nized, with respect to any particular association
5 health plan, as the State with which consultation is
6 required. In carrying out this paragraph—

7 “(A) in the case of a plan which provides
8 health insurance coverage (as defined in section
9 812(a)(3)), such State shall be the State with
10 which filing and approval of a policy type of-
11 fered by the plan was initially obtained, and

12 “(B) in any other case, the Secretary shall
13 take into account the places of residence of the
14 participants and beneficiaries under the plan
15 and the State in which the trust is main-
16 tained.”.

17 **SEC. 236. EFFECTIVE DATE AND TRANSITIONAL AND**
18 **OTHER RULES.**

19 (a) EFFECTIVE DATE.—The amendments made by
20 this subtitle shall take effect 1 year after the date of the
21 enactment of this Act. The Secretary of Labor shall first
22 issue all regulations necessary to carry out the amend-
23 ments made by this subtitle within 1 year after the date
24 of the enactment of this Act.

1 (b) TREATMENT OF CERTAIN EXISTING HEALTH
2 BENEFITS PROGRAMS.—

3 (1) IN GENERAL.—In any case in which, as of
4 the date of the enactment of this Act, an arrange-
5 ment is maintained in a State for the purpose of
6 providing benefits consisting of medical care for the
7 employees and beneficiaries of its participating em-
8 ployers, at least 200 participating employers make
9 contributions to such arrangement, such arrange-
10 ment has been in existence for at least 10 years, and
11 such arrangement is licensed under the laws of one
12 or more States to provide such benefits to its par-
13 ticipating employers, upon the filing with the appli-
14 cable authority (as defined in section 812(a)(5) of
15 the Employee Retirement Income Security Act of
16 1974 (as amended by this subtitle)) by the arrange-
17 ment of an application for certification of the ar-
18 rangement under part 8 of subtitle B of title I of
19 such Act—

20 (A) such arrangement shall be deemed to
21 be a group health plan for purposes of title I
22 of such Act;

23 (B) the requirements of sections 801(a)
24 and 803(a) of the Employee Retirement Income

1 Security Act of 1974 shall be deemed met with
2 respect to such arrangement;

3 (C) the requirements of section 803(b) of
4 such Act shall be deemed met, if the arrange-
5 ment is operated by a board of directors
6 which—

7 (i) is elected by the participating em-
8 ployers, with each employer having one
9 vote; and

10 (ii) has complete fiscal control over
11 the arrangement and which is responsible
12 for all operations of the arrangement;

13 (D) the requirements of section 804(a) of
14 such Act shall be deemed met with respect to
15 such arrangement; and

16 (E) the arrangement may be certified by
17 any applicable authority with respect to its op-
18 erations in any State only if it operates in such
19 State on the date of certification.

20 The provisions of this subsection shall cease to apply
21 with respect to any such arrangement at such time
22 after the date of the enactment of this Act as the
23 applicable requirements of this subsection are not
24 met with respect to such arrangement.

1 (2) DEFINITIONS.—For purposes of this sub-
 2 section, the terms “group health plan”, “medical
 3 care”, and “participating employer” shall have the
 4 meanings provided in section 812 of the Employee
 5 Retirement Income Security Act of 1974, except
 6 that the reference in paragraph (7) of such section
 7 to an “association health plan” shall be deemed a
 8 reference to an arrangement referred to in this sub-
 9 section.

10 **TITLE III—INTERSTATE MARKET**
 11 **FOR HEALTH INSURANCE**

12 **SEC. 301. COOPERATIVE GOVERNING OF INDIVIDUAL**
 13 **HEALTH INSURANCE COVERAGE.**

14 (a) IN GENERAL.—Title XXVII of the Public Health
 15 Service Act (42 U.S.C. 300gg et seq.), as restored by sec-
 16 tion 2, is amended by adding at the end the following new
 17 part:

18 **“PART D—COOPERATIVE GOVERNING OF**
 19 **INDIVIDUAL HEALTH INSURANCE COVERAGE**

20 **“SEC. 2795. DEFINITIONS.**

21 “In this part:

22 “(1) PRIMARY STATE.—The term ‘primary
 23 State’ means, with respect to individual health insur-
 24 ance coverage offered by a health insurance issuer,
 25 the State designated by the issuer as the State

1 whose covered laws shall govern the health insurance
2 issuer in the sale of such coverage under this part.
3 An issuer, with respect to a particular policy, may
4 only designate one such State as its primary State
5 with respect to all such coverage it offers. Such an
6 issuer may not change the designated primary State
7 with respect to individual health insurance coverage
8 once the policy is issued, except that such a change
9 may be made upon renewal of the policy. With re-
10 spect to such designated State, the issuer is deemed
11 to be doing business in that State.

12 “(2) SECONDARY STATE.—The term ‘secondary
13 State’ means, with respect to individual health insur-
14 ance coverage offered by a health insurance issuer,
15 any State that is not the primary State. In the case
16 of a health insurance issuer that is selling a policy
17 in, or to a resident of, a secondary State, the issuer
18 is deemed to be doing business in that secondary
19 State.

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

1 “(4) INDIVIDUAL HEALTH INSURANCE COV-
2 ERAGE.—The term ‘individual health insurance cov-
3 erage’ means health insurance coverage offered in
4 the individual market, as defined in section
5 2791(e)(1), but does not include excepted benefits
6 described in section 2791(c).

7 “(5) APPLICABLE STATE AUTHORITY.—The
8 term ‘applicable State authority’ means, with respect
9 to a health insurance issuer in a State, the State in-
10 surance commissioner or official or officials des-
11 ignated by the State to enforce the requirements of
12 this title for the State with respect to the issuer.

13 “(6) HAZARDOUS FINANCIAL CONDITION.—The
14 term ‘hazardous financial condition’ means that,
15 based on its present or reasonably anticipated finan-
16 cial condition, a health insurance issuer is unlikely
17 to be able—

18 “(A) to meet obligations to policyholders
19 with respect to known claims and reasonably
20 anticipated claims; or

21 “(B) to pay other obligations in the normal
22 course of business.

23 “(7) COVERED LAWS.—

24 “(A) IN GENERAL.—The term ‘covered
25 laws’ means the laws, rules, regulations, agree-

1 ments, and orders governing the insurance busi-
2 ness pertaining to—

3 “(i) individual health insurance cov-
4 erage issued by a health insurance issuer;

5 “(ii) the offer, sale, rating (including
6 medical underwriting), renewal, and
7 issuance of individual health insurance cov-
8 erage to an individual;

9 “(iii) the provision to an individual in
10 relation to individual health insurance cov-
11 erage of health care and insurance related
12 services;

13 “(iv) the provision to an individual in
14 relation to individual health insurance cov-
15 erage of management, operations, and in-
16 vestment activities of a health insurance
17 issuer; and

18 “(v) the provision to an individual in
19 relation to individual health insurance cov-
20 erage of loss control and claims adminis-
21 tration for a health insurance issuer with
22 respect to liability for which the issuer pro-
23 vides insurance.

24 “(B) EXCEPTION.—Such term does not in-
25 clude any law, rule, regulation, agreement, or

1 order governing the use of care or cost manage-
2 ment techniques, including any requirement re-
3 lated to provider contracting, network access or
4 adequacy, health care data collection, or quality
5 assurance.

6 “(8) STATE.—The term ‘State’ means only the
7 50 States and the District of Columbia.

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

11 “(A) Knowingly misrepresenting to claim-
12 ants and insured individuals relevant facts or
13 policy provisions relating to coverage at issue.

14 “(B) Failing to acknowledge with reason-
15 able promptness pertinent communications with
16 respect to claims arising under policies.

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

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

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

1 “(F) Failing to affirm or deny coverage of
2 claims within a reasonable period of time after
3 having completed an investigation related to
4 those claims.

5 “(G) A pattern or practice of compelling
6 insured individuals or their beneficiaries to in-
7 stitute suits to recover amounts due under its
8 policies by offering substantially less than the
9 amounts ultimately recovered in suits brought
10 by them.

11 “(H) A pattern or practice of attempting
12 to settle or settling claims for less than the
13 amount that a reasonable person would believe
14 the insured individual or his or her beneficiary
15 was entitled by reference to written or printed
16 advertising material accompanying or made
17 part of an application.

18 “(I) Attempting to settle or settling claims
19 on the basis of an application that was materi-
20 ally altered without notice to, or knowledge or
21 consent of, the insured.

22 “(J) Failing to provide forms necessary to
23 present claims within 15 calendar days of a re-
24 quests with reasonable explanations regarding
25 their use.

1 “(K) Attempting to cancel a policy in less
2 time than that prescribed in the policy or by the
3 law of the primary State.

4 “(10) FRAUD AND ABUSE.—The term ‘fraud
5 and abuse’ means an act or omission committed by
6 a person who, knowingly and with intent to defraud,
7 commits, or conceals any material information con-
8 cerning, one or more of the following:

9 “(A) Presenting, causing to be presented
10 or preparing with knowledge or belief that it
11 will be presented to or by an insurer, a rein-
12 surer, broker or its agent, false information as
13 part of, in support of or concerning a fact ma-
14 terial to one or more of the following:

15 “(i) An application for the issuance or
16 renewal of an insurance policy or reinsur-
17 ance contract.

18 “(ii) The rating of an insurance policy
19 or reinsurance contract.

20 “(iii) A claim for payment or benefit
21 pursuant to an insurance policy or reinsur-
22 ance contract.

23 “(iv) Premiums paid on an insurance
24 policy or reinsurance contract.

1 “(v) Payments made in accordance
2 with the terms of an insurance policy or
3 reinsurance contract.

4 “(vi) A document filed with the com-
5 missioner or the chief insurance regulatory
6 official of another jurisdiction.

7 “(vii) The financial condition of an in-
8 surer or reinsurer.

9 “(viii) The formation, acquisition,
10 merger, reconsolidation, dissolution or
11 withdrawal from one or more lines of in-
12 surance or reinsurance in all or part of a
13 State by an insurer or reinsurer.

14 “(ix) The issuance of written evidence
15 of insurance.

16 “(x) The reinstatement of an insur-
17 ance policy.

18 “(B) Solicitation or acceptance of new or
19 renewal insurance risks on behalf of an insurer,
20 reinsurer, or other person engaged in the busi-
21 ness of insurance by a person who knows or
22 should know that the insurer or other person
23 responsible for the risk is insolvent at the time
24 of the transaction.

1 “(C) Transaction of the business of insur-
2 ance in violation of laws requiring a license, cer-
3 tificate of authority or other legal authority for
4 the transaction of the business of insurance.

5 “(D) Attempt to commit, aiding or abet-
6 ting in the commission of, or conspiracy to com-
7 mit the acts or omissions specified in this para-
8 graph.

9 **“SEC. 2796. APPLICATION OF LAW.**

10 “(a) IN GENERAL.—The covered laws of the primary
11 State shall apply to individual health insurance coverage
12 offered by a health insurance issuer in the primary State
13 and in any secondary State, but only if the coverage and
14 issuer comply with the conditions of this section with re-
15 spect to the offering of coverage in any secondary State.

16 “(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-
17 ONDARY STATE.—Except as provided in this section, a
18 health insurance issuer with respect to its offer, sale, rat-
19 ing (including medical underwriting), renewal, and
20 issuance of individual health insurance coverage in any
21 secondary State is exempt from any covered laws of the
22 secondary State (and any rules, regulations, agreements,
23 or orders sought or issued by such State under or related
24 to such covered laws) to the extent that such laws would—

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

5 “(A) to pay, on a nondiscriminatory basis,
6 applicable premium and other taxes (including
7 high-risk pool assessments) which are levied on
8 insurers and surplus lines insurers, brokers, or
9 policyholders under the laws of the State;

10 “(B) to register with and designate the
11 State insurance commissioner as its agent solely
12 for the purpose of receiving service of legal doc-
13 uments or process;

14 “(C) to submit to an examination of its fi-
15 nancial condition by the State insurance com-
16 missioner in any State in which the issuer is
17 doing business to determine the issuer’s finan-
18 cial condition, if—

19 “(i) the State insurance commissioner
20 of the primary State has not done an ex-
21 amination within the period recommended
22 by the National Association of Insurance
23 Commissioners; and

24 “(ii) any such examination is con-
25 ducted in accordance with the examiners’

1 handbook of the National Association of
2 Insurance Commissioners and is coordi-
3 nated to avoid unjustified duplication and
4 unjustified repetition;

5 “(D) to comply with a lawful order
6 issued—

7 “(i) in a delinquency proceeding com-
8 menced by the State insurance commis-
9 sioner if there has been a finding of finan-
10 cial impairment under subparagraph (C);

11 or

12 “(ii) in a voluntary dissolution pro-
13 ceeding;

14 “(E) to comply with an injunction issued
15 by a court of competent jurisdiction, upon a pe-
16 tition by the State insurance commissioner al-
17 leging that the issuer is in hazardous financial
18 condition;

19 “(F) to participate, on a nondiscriminatory
20 basis, in any insurance insolvency guaranty as-
21 sociation or similar association to which a
22 health insurance issuer in the State is required
23 to belong;

24 “(G) to comply with any State law regard-
25 ing fraud and abuse (as defined in section

1 2795(10)), except that if the State seeks an in-
2 junction regarding the conduct described in this
3 subparagraph, such injunction must be obtained
4 from a court of competent jurisdiction;

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

8 “(I) to comply with the applicable require-
9 ments for independent review under section
10 2798 with respect to coverage offered in the
11 State;

12 “(2) require any individual health insurance
13 coverage issued by the issuer to be countersigned by
14 an insurance agent or broker residing in that Sec-
15 ondary State; or

16 “(3) otherwise discriminate against the issuer
17 issuing insurance in both the primary State and in
18 any secondary State.

19 “(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A
20 health insurance issuer shall provide the following notice,
21 in 12-point bold type, in any insurance coverage offered
22 in a secondary State under this part by such a health in-
23 surance issuer and at renewal of the policy, with the 5
24 blank spaces therein being appropriately filled with the
25 name of the health insurance issuer, the name of primary

1 State, the name of the secondary State, the name of the
2 secondary State, and the name of the secondary State, re-
3 spectively, for the coverage concerned:

4 This policy is issued by _____ and is governed by
5 the laws and regulations of the State of _____, and
6 it has met all the laws of that State as determined by
7 that State’s Department of Insurance. This policy may be
8 less expensive than others because it is not subject to all
9 of the insurance laws and regulations of the State of
10 _____, including coverage of some services or bene-
11 fits mandated by the law of the State of _____. Ad-
12 ditionally, this policy is not subject to all of the consumer
13 protection laws or restrictions on rate changes of the State
14 of _____. As with all insurance products, before pur-
15 chasing this policy, you should carefully review the policy
16 and determine what health care services the policy covers
17 and what benefits it provides, including any exclusions,
18 limitations, or conditions for such services or benefits.

19 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS
20 AND PREMIUM INCREASES.—

21 “(1) IN GENERAL.—For purposes of this sec-
22 tion, a health insurance issuer that provides indi-
23 vidual health insurance coverage to an individual
24 under this part in a primary or secondary State may
25 not upon renewal—

1 “(A) move or reclassify the individual in-
2 sured under the health insurance coverage from
3 the class such individual is in at the time of
4 issue of the contract based on the health-status
5 related factors of the individual; or

6 “(B) increase the premiums assessed the
7 individual for such coverage based on a health
8 status-related factor or change of a health sta-
9 tus-related factor or the past or prospective
10 claim experience of the insured individual.

11 “(2) CONSTRUCTION.—Nothing in paragraph
12 (1) shall be construed to prohibit a health insurance
13 issuer—

14 “(A) from terminating or discontinuing
15 coverage or a class of coverage in accordance
16 with subsections (b) and (c) of section 2742;

17 “(B) from raising premium rates for all
18 policy holders within a class based on claims ex-
19 perience;

20 “(C) from changing premiums or offering
21 discounted premiums to individuals who engage
22 in wellness activities at intervals prescribed by
23 the issuer, if such premium changes or incen-
24 tives—

1 “(i) are disclosed to the consumer in
2 the insurance contract;

3 “(ii) are based on specific wellness ac-
4 tivities that are not applicable to all indi-
5 viduals; and

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

8 “(D) from reinstating lapsed coverage; or

9 “(E) from retroactively adjusting the rates
10 charged an insured individual if the initial rates
11 were set based on material misrepresentation by
12 the individual at the time of issue.

13 “(e) PRIOR OFFERING OF POLICY IN PRIMARY
14 STATE.—A health insurance issuer may not offer for sale
15 individual health insurance coverage in a secondary State
16 unless that coverage is currently offered for sale in the
17 primary State.

18 “(f) LICENSING OF AGENTS OR BROKERS FOR
19 HEALTH INSURANCE ISSUERS.—Any State may require
20 that a person acting, or offering to act, as an agent or
21 broker for a health insurance issuer with respect to the
22 offering of individual health insurance coverage obtain a
23 license from that State, with commissions or other com-
24 pensation subject to the provisions of the laws of that
25 State, except that a State may not impose any qualifica-

1 tion or requirement which discriminates against a non-
2 resident agent or broker.

3 “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-
4 SURANCE COMMISSIONER.—Each health insurance issuer
5 issuing individual health insurance coverage in both pri-
6 mary and secondary States shall submit—

7 “(1) to the insurance commissioner of each
8 State in which it intends to offer such coverage, be-
9 fore it may offer individual health insurance cov-
10 erage in such State—

11 “(A) a copy of the plan of operation or fea-
12 sibility study or any similar statement of the
13 policy being offered and its coverage (which
14 shall include the name of its primary State and
15 its principal place of business);

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

18 “(C) written notice from the issuer of the
19 issuer’s compliance with all the laws of the pri-
20 mary State; and

21 “(2) to the insurance commissioner of each sec-
22 ondary State in which it offers individual health in-
23 surance coverage, a copy of the issuer’s quarterly fi-
24 nancial statement submitted to the primary State,
25 which statement shall be certified by an independent

1 public accountant and contain a statement of opin-
2 ion on loss and loss adjustment expense reserves
3 made by—

4 “(A) a member of the American Academy
5 of Actuaries; or

6 “(B) a qualified loss reserve specialist.

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

10 “(1) the solicitation or sale of individual health
11 insurance coverage by a health insurance issuer to
12 any person or group who is not eligible for such in-
13 surance; or

14 “(2) the solicitation or sale of individual health
15 insurance coverage that violates the requirements of
16 the law of a secondary State which are described in
17 subparagraphs (A) through (H) of section
18 2796(b)(1).

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

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

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

8 “(2) COURTS OF COMPETENT JURISDICTION.—
9 If a State seeks an injunction regarding the conduct
10 described in paragraphs (1) and (2) of subsection
11 (h), such injunction must be obtained from a Fed-
12 eral or State court of competent jurisdiction.

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

16 “(l) GENERALLY APPLICABLE LAWS.—Nothing in
17 this section shall be construed to affect the applicability
18 of State laws generally applicable to persons or corpora-
19 tions.

20 “(m) GUARANTEED AVAILABILITY OF COVERAGE TO
21 HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a
22 health insurance issuer is offering coverage in a primary
23 State that does not accommodate residents of secondary
24 States or does not provide a working mechanism for resi-
25 dents of a secondary State, and the issuer is offering cov-

1 erage under this part in such secondary State which has
2 not adopted a qualified high-risk pool as its acceptable al-
3 ternative mechanism (as defined in section 2744(c)(2)),
4 the issuer shall, with respect to any individual health in-
5 surance coverage offered in a secondary State under this
6 part, comply with the guaranteed availability requirements
7 for eligible individuals in section 2741.

8 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**
9 **BEFORE ISSUER MAY SELL INTO SECONDARY**
10 **STATES.**

11 “A health insurance issuer may not offer, sell, or
12 issue individual health insurance coverage in a secondary
13 State if the State insurance commissioner does not use
14 a risk-based capital formula for the determination of cap-
15 ital and surplus requirements for all health insurance
16 issuers.

17 **“SEC. 2798. LIMITATION ON INDIVIDUAL PURCHASE IN SEC-**
18 **ONDARY STATE.**

19 “Effective beginning two years after the date of en-
20 actment of this part, an individual in a State may not
21 buy individual health insurance coverage in a secondary
22 State if the premium for individual health insurance in
23 the primary State (with respect to the individual) exceeds
24 the national average premium by 10 percent or more.

1 **“SEC. 2799. INDEPENDENT EXTERNAL APPEALS PROCE-**
2 **DURES.**

3 “(a) **RIGHT TO EXTERNAL APPEAL.**—A health insur-
4 ance issuer may not offer, sell, or issue individual health
5 insurance coverage in a secondary State under the provi-
6 sions of this title unless—

7 “(1) both the secondary State and the primary
8 State have legislation or regulations in place estab-
9 lishing an independent review process for individuals
10 who are covered by individual health insurance cov-
11 erage, or

12 “(2) in any case in which the requirements of
13 subparagraph (A) are not met with respect to the ei-
14 ther of such States, the issuer provides an inde-
15 pendent review mechanism substantially identical (as
16 determined by the applicable State authority of such
17 State) to that prescribed in the ‘Health Carrier Ex-
18 ternal Review Model Act’ of the National Association
19 of Insurance Commissioners for all individuals who
20 purchase insurance coverage under the terms of this
21 part, except that, under such mechanism, the review
22 is conducted by an independent medical reviewer, or
23 a panel of such reviewers, with respect to whom the
24 requirements of subsection (b) are met.

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

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

8 “(A) each independent medical reviewer
9 meets the qualifications described in paragraphs
10 (2) and (3);

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

16 “(C) compensation provided by the issuer
17 to each reviewer is consistent with paragraph
18 (6).

19 “(2) LICENSURE AND EXPERTISE.—Each inde-
20 pendent medical reviewer shall be a physician
21 (allopathic or osteopathic) or health care profes-
22 sional who—

23 “(A) is appropriately credentialed or li-
24 censed in one or more States to deliver health
25 care services; and

1 “(B) typically treats the condition, makes
2 the diagnosis, or provides the type of treatment
3 under review.

4 “(3) INDEPENDENCE.—

5 “(A) IN GENERAL.—Subject to subpara-
6 graph (B), each independent medical reviewer
7 in a case shall—

8 “(i) not be a related party (as defined
9 in paragraph (7));

10 “(ii) not have a material familial, fi-
11 nancial, or professional relationship with
12 such a party; and

13 “(iii) not otherwise have a conflict of
14 interest with such a party (as determined
15 under regulations).

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

18 “(i) prohibit an individual, solely on
19 the basis of affiliation with the issuer,
20 from serving as an independent medical re-
21 viewer if—

22 “(I) a non-affiliated individual is
23 not reasonably available;

1 “(II) the affiliated individual is
2 not involved in the provision of items
3 or services in the case under review;

4 “(III) the fact of such an affili-
5 ation is disclosed to the issuer and the
6 enrollee (or authorized representative)
7 and neither party objects; and

8 “(IV) the affiliated individual is
9 not an employee of the issuer and
10 does not provide services exclusively or
11 primarily to or on behalf of the issuer;

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

20 “(iii) prohibit receipt of compensation
21 by an independent medical reviewer from
22 an entity if the compensation is provided
23 consistent with paragraph (6).

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

1 “(A) IN GENERAL.—In a case involving
2 treatment, or the provision of items or serv-
3 ices—

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

13 “(ii) by a non-physician health care
14 professional, the reviewer, or at least 1
15 member of the review panel, shall be a
16 practicing non-physician health care pro-
17 fessional of the same or similar specialty
18 as the non-physician health care profes-
19 sional who, acting within the appropriate
20 scope of practice within the State in which
21 the service is provided or rendered, typi-
22 cally treats the condition, makes the diag-
23 nosis, or provides the type of treatment
24 under review.

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

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

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

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

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

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

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

24 “(B) The enrollee (or authorized represent-
25 ative).

1 “(C) The health care professional that pro-
2 vides the items or services involved in the de-
3 nial.

4 “(D) The institution at which the items or
5 services (or treatment) involved in the denial
6 are provided.

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

10 “(F) Any other party determined under
11 any regulations to have a substantial interest in
12 the denial involved.

13 “(8) DEFINITIONS.—For purposes of this sub-
14 section:

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

20 “(B) HEALTH CARE PROFESSIONAL.—The
21 term ‘health care professional’ means an indi-
22 vidual who is licensed, accredited, or certified
23 under State law to provide specified health care
24 services and who is operating within the scope
25 of such licensure, accreditation, or certification.

1 **“SEC. 2800. ENFORCEMENT.**

2 “(a) IN GENERAL.—Subject to subsection (b), with
3 respect to specific individual health insurance coverage the
4 primary State for such coverage has sole jurisdiction to
5 enforce the primary State’s covered laws in the primary
6 State and any secondary State.

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

11 “(c) COURT INTERPRETATION.—In reviewing action
12 initiated by the applicable secondary State authority, the
13 court of competent jurisdiction shall apply the covered
14 laws of the primary State.

15 “(d) NOTICE OF COMPLIANCE FAILURE.—In the case
16 of individual health insurance coverage offered in a sec-
17 ondary State that fails to comply with the covered laws
18 of the primary State, the applicable State authority of the
19 secondary State may notify the applicable State authority
20 of the primary State.”.

21 (b) EFFECTIVE DATE.—The amendment made by
22 subsection (a) shall apply to individual health insurance
23 coverage offered, issued, or sold after the date that is one
24 year after the date of the enactment of this Act.

25 (c) GAO ONGOING STUDY AND REPORTS.—

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

5 (A) the number of uninsured and under-in-
6 sured;

7 (B) the availability and cost of health in-
8 surance policies for individuals with pre-existing
9 medical conditions;

10 (C) the availability and cost of health in-
11 surance policies generally;

12 (D) the elimination or reduction of dif-
13 ferent types of benefits under health insurance
14 policies offered in different States; and

15 (E) cases of fraud or abuse relating to
16 health insurance coverage offered under such
17 amendment and the resolution of such cases.

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

23 (d) SEVERABILITY.—If any provision of the section
24 or the application of such provision to any person or cir-
25 cumstance is held to be unconstitutional, the remainder

1 of this section and the application of the provisions of such
 2 to any other person or circumstance shall not be affected.

3 **TITLE IV—SAFETY NET**
 4 **REFORMS**

5 **SEC. 401. REQUIRING OUTREACH AND COVERAGE BEFORE**
 6 **EXPANSION OF ELIGIBILITY.**

7 (a) STATE CHILD HEALTH PLAN REQUIRED TO
 8 SPECIFY HOW IT WILL ACHIEVE COVERAGE FOR 90 PER-
 9 CENT OF TARGETED LOW-INCOME CHILDREN.—

10 (1) IN GENERAL.—Section 2102(a) of the So-
 11 cial Security Act (42 U.S.C. 1397bb(a)) is amend-
 12 ed—

13 (A) in paragraph (6), by striking “and” at
 14 the end;

15 (B) in paragraph (7), by striking the pe-
 16 riod at the end and inserting “; and”; and

17 (C) by adding at the end the following new
 18 paragraph:

19 “(8) how the eligibility and benefits provided
 20 for under the plan for each fiscal year (beginning
 21 with fiscal year 2013) will allow for the State’s an-
 22 nual funding allotment to cover at least 90 percent
 23 of the eligible targeted low-income children in the
 24 State.”.

1 (2) EFFECTIVE DATE.—The amendments made
2 by paragraph (1) shall apply to State child health
3 plans for fiscal years beginning with fiscal year
4 2013.

5 (b) LIMITATION ON PROGRAM EXPANSIONS UNTIL
6 LOWEST INCOME ELIGIBLE INDIVIDUALS ENROLLED.—
7 Section 2105(c) of such Act (42 U.S.C. 1397dd(c)) is
8 amended by adding at the end the following new para-
9 graph:

10 “(12) LIMITATION ON INCREASED COVERAGE
11 OF HIGHER INCOME CHILDREN.—

12 “(A) IN GENERAL.—For child health as-
13 sistance furnished in a fiscal year beginning
14 with fiscal year 2013:

15 “(i) NO PAYMENT FOR CHILDREN
16 WITH FAMILY INCOME ABOVE 300 PERCENT
17 OF POVERTY LINE.—Payment shall not be
18 made under this section for child health
19 assistance for a targeted low-income child
20 in a family the income of which exceeds
21 300 percent of the poverty line applicable
22 to a family of the size involved.

23 “(ii) SPECIAL RULES FOR PAYMENT
24 FOR CHILDREN WITH FAMILY INCOME
25 ABOVE 200 PERCENT OF POVERTY LINE.—

1 In the case of child health assistance for a
2 targeted low-income child in a family the
3 income of which exceeds 200 percent (but
4 does not exceed 300 percent) of the pov-
5 erty line applicable to a family of the size
6 involved no payment shall be made under
7 this section for such assistance unless the
8 State demonstrates to the satisfaction of
9 the Secretary that—

10 “(I) the State has met the 90
11 percent retrospective coverage test
12 specified in subparagraph (B)(i) for
13 the previous fiscal year; and

14 “(II) the State will meet the 90
15 percent prospective coverage test spec-
16 ified in subparagraph (B)(ii) for the
17 fiscal year.

18 “(B) 90 PERCENT COVERAGE TESTS.—

19 “(i) RETROSPECTIVE TEST.—The 90
20 percent retrospective coverage test speci-
21 fied in this clause is, for a State for a fis-
22 cal year, that on average during the fiscal
23 year, the State has enrolled under this title
24 or title XIX at least 90 percent of the indi-
25 viduals residing in the State who—

1 “(I) are children under 19 years
2 of age (or are pregnant women) and
3 are eligible for medical assistance
4 under title XIX; or

5 “(II) are targeted low-income
6 children whose family income does not
7 exceed 200 percent of the poverty line
8 and who are eligible for child health
9 assistance under this title.

10 “(ii) PROSPECTIVE TEST.—The 90
11 percent prospective test specified in this
12 clause is, for a State for a fiscal year, that
13 on average during the fiscal year, the State
14 will enroll under this title or title XIX at
15 least 90 percent of the individuals residing
16 in the State who—

17 “(I) are children under 19 years
18 of age (or are pregnant women) and
19 are eligible for medical assistance
20 under title XIX; or

21 “(II) are targeted low-income
22 children whose family income does not
23 exceed such percent of the poverty
24 line (in excess of 200 percent) as the
25 State elects consistent with this para-

1 graph and who are eligible for child
2 health assistance under this title.

3 “(C) GRANDFATHER.—Clauses (i) and (ii)
4 of subparagraph (A) shall not apply to the pro-
5 vision of child health assistance—

6 “(i) to a targeted low-income child
7 who is enrolled for child health assistance
8 under this title as of September 30, 2010;

9 “(ii) to a pregnant woman who is en-
10 rolled for assistance under this title as of
11 September 30, 2011, through the comple-
12 tion of the post-partum period following
13 completion of her pregnancy; and

14 “(iii) for items and services furnished
15 before October 1, 2012, to an individual
16 who is not a targeted low-income child and
17 who is enrolled for assistance under this
18 title as of September 30, 2011.

19 “(D) TREATMENT OF PREGNANT
20 WOMEN.—In this paragraph and sections
21 2102(a)(8) and 2104(a)(2), the term ‘targeted
22 low-income child’ includes an individual under
23 age 19, including the period from conception to
24 birth, who is eligible for child health assistance
25 under this title by virtue of the definition of the

1 term ‘child’ under section 457.10 of title 42,
2 Code of Federal Regulations.”.

3 (c) STANDARDIZATION OF INCOME DETERMINA-
4 TIONS.—

5 (1) IN GENERAL.—Section 2110(d) of such Act
6 (42 U.S.C. 1397jj) is amended by adding at the end
7 the following new subsection:

8 “(d) STANDARDIZATION OF INCOME DETERMINA-
9 TIONS.—In determining family income under this title (in-
10 cluding in the case of a State child health plan that pro-
11 vides health benefits coverage in the manner described in
12 section 2101(a)(2)), a State shall base such determination
13 on gross income (including amounts that would be in-
14 cluded in gross income if they were not exempt from in-
15 come taxation) and may only take into consideration such
16 income disregards as the Secretary shall develop.”.

17 (2) EFFECTIVE DATE.—(A) Subject to subpara-
18 graph (B), the amendment made by paragraph (1)
19 shall apply to determinations (and redeterminations)
20 of income made on or after April 1, 2012.

21 (B) In the case of a State child health plan
22 under title XXI of the Social Security Act which the
23 Secretary of Health and Human Services determines
24 requires State legislation (other than legislation ap-
25 propriating funds) in order for the plan to meet the

1 additional requirement imposed by the amendment
2 made by paragraph (1), the State child health plan
3 shall not be regarded as failing to comply with the
4 requirements of such title solely on the basis of its
5 failure to meet this additional requirement before
6 the first day of the first calendar quarter beginning
7 after the close of the first regular session of the
8 State legislature that begins after the date of the en-
9 actment of this Act. For purposes of the previous
10 sentence, in the case of a State that has a 2-year
11 legislative session, each year of such session shall be
12 deemed to be a separate regular session of the State
13 legislature.

14 **SEC. 402. EASING ADMINISTRATIVE BARRIERS TO STATE**
15 **COOPERATION WITH EMPLOYER-SPONSORED**
16 **INSURANCE COVERAGE.**

17 (a) **REQUIRING SOME COVERAGE FOR EMPLOYER-**
18 **SPONSORED INSURANCE UNDER CHIP.**—Section 2102(a)
19 of the Social Security Act (42 U.S.C. 1397b(a)), as
20 amended by section 401(a), is amended—

21 (1) in paragraph (7), by striking “and” at the
22 end;

23 (2) in paragraph (8), by striking the period at
24 the end and inserting “; and”; and

1 (3) by adding at the end the following new
2 paragraph:

3 “(9) effective for plan years beginning on or
4 after October 1, 2012, how the plan will provide for
5 child health assistance with respect to targeted low-
6 income children covered under a group health
7 plan.”.

8 (b) FEDERAL FINANCIAL PARTICIPATION FOR EM-
9 PLOYER-SPONSORED INSURANCE.—Section 2105 of such
10 Act (42 U.S.C. 1397d) is amended—

11 (1) in subsection (a)(1)(C), by inserting before
12 the semicolon at the end the following: “and, subject
13 to paragraph (3)(C), in the form of payment of the
14 premiums for coverage under a group health plan
15 that includes coverage of targeted low-income chil-
16 dren and benefits supplemental to such coverage”;
17 and

18 (2) by amending paragraph (3) of subsection
19 (c) to read as follows:

20 “(3) PURCHASE OF EMPLOYER-SPONSORED IN-
21 SURANCE.—

22 “(A) IN GENERAL.—Payment may be
23 made to a State under subsection (a)(1)(C),
24 subject to the provisions of this paragraph, for
25 the purchase of family coverage under a group

1 health plan that includes coverage of targeted
2 low-income children unless such coverage would
3 otherwise substitute for coverage that would be
4 provided to such children but for the purchase
5 of family coverage.

6 “(B) WAIVER OF CERTAIN PROVISIONS.—

7 With respect to coverage described in subpara-
8 graph (A)—

9 “(i) notwithstanding section 2102, no
10 minimum benefits requirement (other than
11 those otherwise applicable with respect to
12 services referred to in section 2102(a)(7))
13 under this title shall apply; and

14 “(ii) no limitation on beneficiary cost-
15 sharing otherwise applicable under this
16 title or title XIX shall apply.

17 “(C) REQUIRED PROVISION OF SUPPLE-

18 MENTAL BENEFITS.—If the coverage described
19 in subparagraph (A) does not provide coverage
20 for the services referred to in section
21 2102(a)(7), the State child health plan shall
22 provide coverage of such services as supple-
23 mental benefits.

24 “(D) LIMITATION ON FFP.—The amount
25 of the payment under paragraph (1)(C) for cov-

1 erage described in subparagraph (A) (and sup-
2 plemental benefits under subparagraph (C) for
3 individuals so covered) during a fiscal year may
4 not exceed the product of—

5 “(i) the national per capita expendi-
6 ture under this title (taking into account
7 both Federal and State expenditures) for
8 the previous fiscal year (as determined by
9 the Secretary using the best available
10 data);

11 “(ii) the enhanced FMAP for the
12 State and fiscal year involved; and

13 “(iii) the number of targeted low-in-
14 come children for whom such coverage is
15 provided.

16 “(E) VOLUNTARY ENROLLMENT.—A State
17 child health plan—

18 “(i) may not require a targeted low-
19 income child to enroll in coverage described
20 in subparagraph (A) in order to obtain
21 child health assistance under this title;

22 “(ii) before providing such child
23 health assistance for such coverage of a
24 child, shall make available (which may be
25 through an Internet Web site or other

1 means including the State transparency
2 plan portal established under section 901
3 of the Empowering Patients First Act) to
4 the parent or guardian of the child infor-
5 mation on the coverage available under
6 this title, including benefits and cost-shar-
7 ing; and

8 “(iii) shall provide at least one oppor-
9 tunity per fiscal year for beneficiaries to
10 switch coverage under this title from cov-
11 erage described in subparagraph (A) to the
12 coverage that is otherwise made available
13 under this title.

14 “(F) INFORMATION ON COVERAGE OP-
15 TIONS.—A State child health plan shall—

16 “(i) describe how the State will notify
17 potential beneficiaries of coverage de-
18 scribed in subparagraph (A);

19 “(ii) provide such notification in writ-
20 ing at least during the initial application
21 for enrollment under this title and during
22 redeterminations of eligibility if the indi-
23 vidual was enrolled before October 1, 2012;
24 and

1 “(iii) post a description of these cov-
2 erage options on any official Web site that
3 may be established by the State in connec-
4 tion with the plan, including the State
5 transparency plan portal established under
6 section 901 of the Empowering Patients
7 First Act.

8 “(G) SEMIANNUAL VERIFICATION OF COV-
9 ERAGE.—If coverage described in subparagraph
10 (A) is provided under a group health plan with
11 respect to a targeted low-income child, the
12 State child health plan shall provide for the col-
13 lection, at least once every six months, of proof
14 from the plan that the child is enrolled in such
15 coverage.

16 “(H) RULE OF CONSTRUCTION.—Nothing
17 in this section is to be construed to prohibit a
18 State from—

19 “(i) offering wrap around benefits in
20 order for a group health plan to meet any
21 State-established minimum benefit require-
22 ments;

23 “(ii) establishing a cost-effectiveness
24 test to qualify for coverage under such a
25 plan;

1 “(iii) establishing limits on beneficiary
2 cost-sharing under such a plan;

3 “(iv) paying all or part of a bene-
4 ficiary’s cost-sharing requirements under
5 such a plan;

6 “(v) paying less than the full cost of
7 the employee’s share of the premium under
8 such a plan, including prorating the cost of
9 the premium to pay for only what the
10 State determines is the portion of the pre-
11 mium that covers targeted low-income chil-
12 dren;

13 “(vi) using State funds to pay for
14 benefits above the Federal upper limit es-
15 tablished under subparagraph (C);

16 “(vii) allowing beneficiaries enrolled in
17 group health plans from changing plans to
18 another coverage option available under
19 this title at any time; or

20 “(viii) providing any guidance or in-
21 formation it deems appropriate in order to
22 help beneficiaries make an informed deci-
23 sion regarding the option to enroll in cov-
24 erage described in subparagraph (A).

1 “(I) GROUP HEALTH PLAN DEFINED.—In
 2 this paragraph, the term ‘group health plan’
 3 has the meaning given such term in section
 4 2791(a)(1) of the Public Health Service Act (42
 5 U.S.C. 300gg–91(a)(1)).”.

6 (c) APPLICATION UNDER MEDICAID.—The Secretary
 7 of Health and Human Services shall provide for the appli-
 8 cation of the amendments made by subsections (a) and
 9 (b) under the Medicaid program under title XIX of the
 10 Social Security Act in the same manner as such amend-
 11 ments apply to SCHIP under title XXI of such Act.

12 **SEC. 403. IMPROVING BENEFICIARY CHOICE IN SCHIP.**

13 (a) REQUIRING OFFERING OF ALTERNATIVE COV-
 14 ERAGE OPTIONS.—Section 2102 of the Social Security Act
 15 (42 U.S.C. 1397b), as amended by sections 401(a) and
 16 402(a), is amended—

17 (1) in subsection (a)—

18 (A) in paragraph (8), by striking “and” at
 19 the end;

20 (B) in paragraph (9), by striking the pe-
 21 riod at the end and inserting “; and”; and

22 (C) by adding at the end the following new
 23 paragraph:

24 “(10) effective for plan years beginning on or
 25 after October 1, 2012, how the plan will provide for

1 child health assistance with respect to targeted low-
2 income children through alternative coverage options
3 in accordance with subsection (e).”; and

4 (2) by adding at the end the following new sub-
5 section:

6 “(d) ALTERNATIVE COVERAGE OPTIONS.—

7 “(1) IN GENERAL.—Effective October 1, 2012,
8 a State child health plan shall provide for the offer-
9 ing of any qualified alternative coverage that a
10 qualified entity seeks to offer to targeted low-income
11 children through the plan in the State.

12 “(2) APPLICATION OF UNIFORM FINANCIAL
13 LIMITATION FOR ALL ALTERNATIVE COVERAGE OP-
14 TIONS.—With respect to all qualified alternative cov-
15 erage offered in a State, the State child health plan
16 shall establish a uniform dollar limitation on the per
17 capita monthly amount that will be paid by the
18 State to the qualified entity with respect to such
19 coverage provided to a targeted low-income child.
20 Such limitation may not be less than 90 percent of
21 the per capita monthly payment made for coverage
22 offered under the State child health plan that is not
23 in the form of an alternative coverage option. Noth-
24 ing in this paragraph shall be construed—

1 “(A) as requiring a State to provide for
2 the full payment of premiums for qualified al-
3 ternative coverage;

4 “(B) as preventing a State from charging
5 additional premiums to cover the difference be-
6 tween the cost of qualified alternative coverage
7 and the amount of such payment limitation; or

8 “(C) as preventing a State from using its
9 own funds to provide a dollar limitation that ex-
10 ceeds the Federal financial participation as lim-
11 ited under section 2105(c)(10).

12 “(3) TREATMENT OF LOW COST COVERAGE.—

13 “(A) IN GENERAL.—Except as provided in
14 subparagraph (B), if the uniform dollar limita-
15 tion under paragraph (2) exceeds the premium
16 for qualified alternative coverage for an en-
17 rollee, then such excess shall be refunded to the
18 Federal and State governments in the same
19 proportion as is otherwise applicable to recov-
20 ered funds under this title.

21 “(B) EXCEPTION FOR HIGH-DEDUCTIBLE
22 HEALTH PLANS.—In the case of coverage under
23 a high-deductible health plan, the excess de-
24 scribed in subparagraph (A) shall be deposited

1 into a health savings account established with
2 respect to such plan.

3 “(4) EXEMPTION.—A State is not subject to
4 the requirement of paragraph (1) if the State child
5 health plan provides, as of the date of the enactment
6 of this subsection, for a cash out or health savings
7 account type option for those enrolled under the
8 plan.

9 “(5) QUALIFIED ALTERNATIVE COVERAGE DE-
10 FINED.—In this section, the term ‘qualified alter-
11 native coverage’ means health insurance coverage
12 that—

13 “(A) meets the coverage requirements of
14 section 2103 (other than cost-sharing require-
15 ments of such section); and

16 “(B) is offered by a qualified insurer, and
17 not directly by the State.

18 “(6) QUALIFIED INSURER DEFINED.—In this
19 section, the term ‘qualified insurer’ means, with re-
20 spect to a State, an entity that is licensed to offer
21 health insurance coverage in the State.”.

22 (b) FEDERAL FINANCIAL PARTICIPATION FOR
23 QUALIFIED ALTERNATIVE COVERAGE.—Section 2105 of
24 such Act (42 U.S.C. 1397d) is amended—

1 (1) in subsection (a)(1)(C), as amended by sec-
2 tion 402(b), by inserting before the semicolon at the
3 end the following: “and, subject to paragraph
4 (13)(C), in the form of payment of the premiums for
5 coverage for qualified alternative coverage”; and

6 (2) in subsection (c), as amended by section
7 401(b) by adding at the end the following new para-
8 graph:

9 “(13) PURCHASE OF QUALIFIED ALTERNATIVE
10 COVERAGE.—

11 “(A) IN GENERAL.—Payment may be
12 made to a State under subsection (a)(1)(C),
13 subject to the provisions of this paragraph, for
14 the purchase of qualified alternative coverage.

15 “(B) WAIVER OF CERTAIN PROVISIONS.—
16 With respect to coverage described in subpara-
17 graph (A), no limitation on beneficiary cost-
18 sharing otherwise applicable under this title or
19 title XIX shall apply.

20 “(C) LIMITATION ON FFP.—The amount of
21 the payment under paragraph (1)(C) for cov-
22 erage described in subparagraph (A) during a
23 fiscal year in the aggregate for all such cov-
24 erage in the State may not exceed the product
25 of—

1 “(i) the national per capita expendi-
2 ture under this title (taking into account
3 both Federal and State expenditures) for
4 the previous fiscal year (as determined by
5 the Secretary using the best available
6 data);

7 “(ii) the enhanced FMAP for the
8 State and fiscal year involved; and

9 “(iii) the number of targeted low-in-
10 come children for whom such coverage is
11 provided.

12 “(D) VOLUNTARY ENROLLMENT.—A State
13 child health plan—

14 “(i) may not require a targeted low-
15 income child to enroll in coverage described
16 in subparagraph (A) in order to obtain
17 child health assistance under this title;

18 “(ii) before providing such child
19 health assistance for such coverage of a
20 child, shall make available (which may be
21 through an Internet Web site or other
22 means) to the parent or guardian of the
23 child information on the coverage available
24 under this title, including benefits and
25 cost-sharing; and

1 “(iii) shall provide at least one oppor-
2 tunity per fiscal year for beneficiaries to
3 switch coverage under this title from cov-
4 erage described in subparagraph (A) to the
5 coverage that is otherwise made available
6 under this title.

7 “(E) INFORMATION ON COVERAGE OP-
8 TIONS.—A State child health plan shall—

9 “(i) describe how the State will notify
10 potential beneficiaries of coverage de-
11 scribed in subparagraph (A);

12 “(ii) provide such notification in writ-
13 ing at least during the initial application
14 for enrollment under this title and during
15 redeterminations of eligibility if the indi-
16 vidual was enrolled before October 1, 2012;
17 and

18 “(iii) post a description of these cov-
19 erage options on any official Web site that
20 may be established by the State in connec-
21 tion with the plan.

22 “(F) RULE OF CONSTRUCTION.—Nothing
23 in this section is to be construed to prohibit a
24 State from—

1 “(i) establishing limits on beneficiary
2 cost-sharing under such alternative cov-
3 erage;

4 “(ii) paying all or part of a bene-
5 ficiary’s cost-sharing requirements under
6 such coverage;

7 “(iii) paying less than the full cost of
8 a child’s share of the premium under such
9 coverage, insofar as the premium for such
10 coverage exceeds the limitation established
11 by the State under subparagraph (C);

12 “(iv) using State funds to pay for
13 benefits above the Federal upper limit es-
14 tablished under subparagraph (C); or

15 “(v) providing any guidance or infor-
16 mation it deems appropriate in order to
17 help beneficiaries make an informed deci-
18 sion regarding the option to enroll in cov-
19 erage described in subparagraph (A).”.

20 (c) APPLICATION UNDER MEDICAID.—The Secretary
21 of Health and Human Services shall provide for the appli-
22 cation of the amendments made by subsections (a) and
23 (b) under the Medicaid program under title XIX of the
24 Social Security Act in the same manner as such amend-
25 ments apply to SCHIP under title XXI of such Act.

1 **TITLE V—MEDICAL LIABILITY**
2 **REFORMS**

3 **SEC. 501. SHORT TITLE.**

4 This title may be cited as the “Help Efficient, Acces-
5 sible, Low-cost, Timely Healthcare (HEALTH) Act of
6 2011”.

7 **SEC. 502. FINDINGS AND PURPOSE.**

8 (a) FINDINGS.—

9 (1) EFFECT ON HEALTH CARE ACCESS AND
10 COSTS.—Congress finds that our current civil justice
11 system is adversely affecting patient access to health
12 care services, better patient care, and cost-efficient
13 health care, in that the health care liability system
14 is a costly and ineffective mechanism for resolving
15 claims of health care liability and compensating in-
16 jured patients, and is a deterrent to the sharing of
17 information among health care professionals which
18 impedes efforts to improve patient safety and quality
19 of care.

20 (2) EFFECT ON INTERSTATE COMMERCE.—

21 Congress finds that the health care and insurance
22 industries are industries affecting interstate com-
23 merce and the health care liability litigation systems
24 existing throughout the United States are activities
25 that affect interstate commerce by contributing to

1 the high costs of health care and premiums for
2 health care liability insurance purchased by health
3 care system providers.

4 (3) EFFECT ON FEDERAL SPENDING.—Con-
5 gress finds that the health care liability litigation
6 systems existing throughout the United States have
7 a significant effect on the amount, distribution, and
8 use of Federal funds because of—

9 (A) the large number of individuals who
10 receive health care benefits under programs op-
11 erated or financed by the Federal Government;

12 (B) the large number of individuals who
13 benefit because of the exclusion from Federal
14 taxes of the amounts spent to provide them
15 with health insurance benefits; and

16 (C) the large number of health care pro-
17 viders who provide items or services for which
18 the Federal Government makes payments.

19 (b) PURPOSE.—It is the purpose of this title to imple-
20 ment reasonable, comprehensive, and effective health care
21 liability reforms designed to

22 (1) improve the availability of health care serv-
23 ices in cases in which health care liability actions
24 have been shown to be a factor in the decreased
25 availability of services;

1 (2) reduce the incidence of “defensive medi-
2 cine” and lower the cost of health care liability in-
3 surance, all of which contribute to the escalation of
4 health care costs;

5 (3) ensure that persons with meritorious health
6 care injury claims receive fair and adequate com-
7 pensation, including reasonable noneconomic dam-
8 ages;

9 (4) improve the fairness and cost-effectiveness
10 of our current health care liability system to resolve
11 disputes over, and provide compensation for, health
12 care liability by reducing uncertainty in the amount
13 of compensation provided to injured individuals; and

14 (5) provide an increased sharing of information
15 in the health care system which will reduce unin-
16 tended injury and improve patient care.

17 **SEC. 503. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.**

18 The time for the commencement of a health care law-
19 suit shall be 3 years after the date of manifestation of
20 injury or 1 year after the claimant discovers, or through
21 the use of reasonable diligence should have discovered, the
22 injury, whichever occurs first. In no event shall the time
23 for commencement of a health care lawsuit exceed 3 years
24 after the date of manifestation of injury unless tolled for
25 any of the following—

- 1 (1) upon proof of fraud;
- 2 (2) intentional concealment; or
- 3 (3) the presence of a foreign body, which has no
- 4 therapeutic or diagnostic purpose or effect, in the
- 5 person of the injured person.

6 Actions by a minor shall be commenced within 3 years
7 from the date of the alleged manifestation of injury except
8 that actions by a minor under the full age of 6 years shall
9 be commenced within 3 years of manifestation of injury
10 or prior to the minor's 8th birthday, whichever provides
11 a longer period. Such time limitation shall be tolled for
12 minors for any period during which a parent or guardian
13 and a health care provider or health care organization
14 have committed fraud or collusion in the failure to bring
15 an action on behalf of the injured minor.

16 **SEC. 504. COMPENSATING PATIENT INJURY.**

17 (a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL
18 ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any
19 health care lawsuit, nothing in this title shall limit a claim-
20 ant's recovery of the full amount of the available economic
21 damages, notwithstanding the limitation in subsection (b).

22 (b) ADDITIONAL NONECONOMIC DAMAGES.—In any
23 health care lawsuit, the amount of noneconomic damages,
24 if available, may be as much as \$250,000, regardless of
25 the number of parties against whom the action is brought

1 or the number of separate claims or actions brought with
2 respect to the same injury.

3 (c) NO DISCOUNT OF AWARD FOR NONECONOMIC
4 DAMAGES.—For purposes of applying the limitation in
5 subsection (b), future noneconomic damages shall not be
6 discounted to present value. The jury shall not be in-
7 formed about the maximum award for noneconomic dam-
8 ages. An award for noneconomic damages in excess of
9 \$250,000 shall be reduced either before the entry of judg-
10 ment, or by amendment of the judgment after entry of
11 judgment, and such reduction shall be made before ac-
12 counting for any other reduction in damages required by
13 law. If separate awards are rendered for past and future
14 noneconomic damages and the combined awards exceed
15 \$250,000, the future noneconomic damages shall be re-
16 duced first.

17 (d) FAIR SHARE RULE.—In any health care lawsuit,
18 each party shall be liable for that party's several share
19 of any damages only and not for the share of any other
20 person. Each party shall be liable only for the amount of
21 damages allocated to such party in direct proportion to
22 such party's percentage of responsibility. Whenever a
23 judgment of liability is rendered as to any party, a sepa-
24 rate judgment shall be rendered against each such party
25 for the amount allocated to such party. For purposes of

1 this section, the trier of fact shall determine the propor-
2 tion of responsibility of each party for the claimant's
3 harm.

4 **SEC. 505. MAXIMIZING PATIENT RECOVERY.**

5 (a) COURT SUPERVISION OF SHARE OF DAMAGES
6 ACTUALLY PAID TO CLAIMANTS.—In any health care law-
7 suit, the court shall supervise the arrangements for pay-
8 ment of damages to protect against conflicts of interest
9 that may have the effect of reducing the amount of dam-
10 ages awarded that are actually paid to claimants. In par-
11 ticular, in any health care lawsuit in which the attorney
12 for a party claims a financial stake in the outcome by vir-
13 tue of a contingent fee, the court shall have the power
14 to restrict the payment of a claimant's damage recovery
15 to such attorney, and to redirect such damages to the
16 claimant based upon the interests of justice and principles
17 of equity. In no event shall the total of all contingent fees
18 for representing all claimants in a health care lawsuit ex-
19 ceed the following limits:

20 (1) Forty percent of the first \$50,000 recovered
21 by the claimant(s).

22 (2) Thirty-three and one-third percent of the
23 next \$50,000 recovered by the claimant(s).

24 (3) Twenty-five percent of the next \$500,000
25 recovered by the claimant(s).

1 (4) Fifteen percent of any amount by which the
2 recovery by the claimant(s) is in excess of \$600,000.

3 (b) APPLICABILITY.—The limitations in this section
4 shall apply whether the recovery is by judgment, settle-
5 ment, mediation, arbitration, or any other form of alter-
6 native dispute resolution. In a health care lawsuit involv-
7 ing a minor or incompetent person, a court retains the
8 authority to authorize or approve a fee that is less than
9 the maximum permitted under this section. The require-
10 ment for court supervision in the first two sentences of
11 subsection (a) applies only in civil actions.

12 **SEC. 506. ADDITIONAL HEALTH BENEFITS.**

13 In any health care lawsuit involving injury or wrong-
14 ful death, any party may introduce evidence of collateral
15 source benefits. If a party elects to introduce such evi-
16 dence, any opposing party may introduce evidence of any
17 amount paid or contributed or reasonably likely to be paid
18 or contributed in the future by or on behalf of the oppos-
19 ing party to secure the right to such collateral source bene-
20 fits. No provider of collateral source benefits shall recover
21 any amount against the claimant or receive any lien or
22 credit against the claimant's recovery or be equitably or
23 legally subrogated to the right of the claimant in a health
24 care lawsuit involving injury or wrongful death. This sec-
25 tion shall apply to any health care lawsuit that is settled

1 as well as a health care lawsuit that is resolved by a fact
2 finder. This section shall not apply to section 1862(b) (42
3 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C.
4 1396a(a)(25)) of the Social Security Act.

5 **SEC. 507. PUNITIVE DAMAGES.**

6 (a) IN GENERAL.—Punitive damages may, if other-
7 wise permitted by applicable State or Federal law, be
8 awarded against any person in a health care lawsuit only
9 if it is proven by clear and convincing evidence that such
10 person acted with malicious intent to injure the claimant,
11 or that such person deliberately failed to avoid unneces-
12 sary injury that such person knew the claimant was sub-
13 stantially certain to suffer. In any health care lawsuit
14 where no judgment for compensatory damages is rendered
15 against such person, no punitive damages may be awarded
16 with respect to the claim in such lawsuit. No demand for
17 punitive damages shall be included in a health care lawsuit
18 as initially filed. A court may allow a claimant to file an
19 amended pleading for punitive damages only upon a mo-
20 tion by the claimant and after a finding by the court, upon
21 review of supporting and opposing affidavits or after a
22 hearing, after weighing the evidence, that the claimant has
23 established by a substantial probability that the claimant
24 will prevail on the claim for punitive damages. At the re-

1 quest of any party in a health care lawsuit, the trier of
2 fact shall consider in a separate proceeding—

3 (1) whether punitive damages are to be award-
4 ed and the amount of such award; and

5 (2) the amount of punitive damages following a
6 determination of punitive liability.

7 If a separate proceeding is requested, evidence relevant
8 only to the claim for punitive damages, as determined by
9 applicable State law, shall be inadmissible in any pro-
10 ceeding to determine whether compensatory damages are
11 to be awarded.

12 (b) DETERMINING AMOUNT OF PUNITIVE DAM-
13 AGES.—

14 (1) FACTORS CONSIDERED.—In determining
15 the amount of punitive damages, if awarded, in a
16 health care lawsuit, the trier of fact shall consider
17 only the following—

18 (A) the severity of the harm caused by the
19 conduct of such party;

20 (B) the duration of the conduct or any
21 concealment of it by such party;

22 (C) the profitability of the conduct to such
23 party;

24 (D) the number of products sold or med-
25 ical procedures rendered for compensation, as

1 the case may be, by such party, of the kind
2 causing the harm complained of by the claim-
3 ant;

4 (E) any criminal penalties imposed on such
5 party, as a result of the conduct complained of
6 by the claimant; and

7 (F) the amount of any civil fines assessed
8 against such party as a result of the conduct
9 complained of by the claimant.

10 (2) MAXIMUM AWARD.—The amount of punitive
11 damages, if awarded, in a health care lawsuit may
12 be as much as \$250,000 or as much as two times
13 the amount of economic damages awarded, which-
14 ever is greater. The jury shall not be informed of
15 this limitation.

16 (c) NO PUNITIVE DAMAGES FOR PRODUCTS THAT
17 COMPLY WITH FDA STANDARDS.—

18 (1) IN GENERAL.—

19 (A) No punitive damages may be awarded
20 against the manufacturer or distributor of a
21 medical product, or a supplier of any compo-
22 nent or raw material of such medical product,
23 based on a claim that such product caused the
24 claimant's harm where—

1 (i)(I) such medical product was sub-
2 ject to premarket approval, clearance, or li-
3 censure by the Food and Drug Administra-
4 tion with respect to the safety of the for-
5 mulation or performance of the aspect of
6 such medical product which caused the
7 claimant's harm or the adequacy of the
8 packaging or labeling of such medical
9 product; and

10 (II) such medical product was so ap-
11 proved, cleared, or licensed; or

12 (ii) such medical product is generally
13 recognized among qualified experts as safe
14 and effective pursuant to conditions estab-
15 lished by the Food and Drug Administra-
16 tion and applicable Food and Drug Admin-
17 istration regulations, including without
18 limitation those related to packaging and
19 labeling, unless the Food and Drug Admin-
20 istration has determined that such medical
21 product was not manufactured or distrib-
22 uted in substantial compliance with appli-
23 cable Food and Drug Administration stat-
24 utes and regulations.

1 (B) RULE OF CONSTRUCTION.—Subpara-
2 graph (A) may not be construed as establishing
3 the obligation of the Food and Drug Adminis-
4 tration to demonstrate affirmatively that a
5 manufacturer, distributor, or supplier referred
6 to in such subparagraph meets any of the con-
7 ditions described in such subparagraph.

8 (2) LIABILITY OF HEALTH CARE PROVIDERS.—
9 A health care provider who prescribes, or who dis-
10 penses pursuant to a prescription, a medical product
11 approved, licensed, or cleared by the Food and Drug
12 Administration shall not be named as a party to a
13 product liability lawsuit involving such product and
14 shall not be liable to a claimant in a class action
15 lawsuit against the manufacturer, distributor, or
16 seller of such product. Nothing in this paragraph
17 prevents a court from consolidating cases involving
18 health care providers and cases involving products li-
19 ability claims against the manufacturer, distributor,
20 or product seller of such medical product.

21 (3) PACKAGING.—In a health care lawsuit for
22 harm which is alleged to relate to the adequacy of
23 the packaging or labeling of a drug which is required
24 to have tamper-resistant packaging under regula-
25 tions of the Secretary of Health and Human Serv-

1 ices (including labeling regulations related to such
2 packaging), the manufacturer or product seller of
3 the drug shall not be held liable for punitive dam-
4 ages unless such packaging or labeling is found by
5 the trier of fact by clear and convincing evidence to
6 be substantially out of compliance with such regula-
7 tions.

8 (4) EXCEPTION.—Paragraph (1) shall not
9 apply in any health care lawsuit in which—

10 (A) a person, before or after premarket ap-
11 proval, clearance, or licensure of such medical
12 product, knowingly misrepresented to or with-
13 held from the Food and Drug Administration
14 information that is required to be submitted
15 under the Federal Food, Drug, and Cosmetic
16 Act (21 U.S.C. 301 et seq.) or section 351 of
17 the Public Health Service Act (42 U.S.C. 262)
18 that is material and is causally related to the
19 harm which the claimant allegedly suffered;

20 (B) a person made an illegal payment to
21 an official of the Food and Drug Administra-
22 tion for the purpose of either securing or main-
23 taining approval, clearance, or licensure of such
24 medical product; or

1 (C) the defendant caused the medical prod-
2 uct which caused the claimant's harm to be
3 misbranded or adulterated (as such terms are
4 used in chapter V of the Federal Food, Drug,
5 and Cosmetic Act (21 U.S.C. 351 et seq.)).

6 **SEC. 508. LIMITATION ON RECOVERY IN A HEALTH CARE**
7 **LAWSUIT BASED ON COMPLIANCE WITH BEST**
8 **PRACTICE GUIDELINES.**

9 (a) SELECTION AND ISSUANCE OF BEST PRACTICES
10 GUIDELINES.—

11 (1) IN GENERAL.—The Secretary of Health and
12 Human Services (in this section referred to as the
13 “Secretary”) shall provide for the selection and
14 issuance of best practice guidelines for treatment of
15 medical conditions (each in this subsection referred
16 to as a “guideline”) in accordance with paragraphs
17 (2) and (3).

18 (2) DEVELOPMENT PROCESS.—Not later than
19 90 days after the date of enactment of this title, the
20 Secretary shall enter into a contract with a qualified
21 physician consensus-building organization (such as
22 the Physician Consortium for Performance Improve-
23 ment), in concert and agreement with physician spe-
24 cialty organizations, to develop guidelines. The con-
25 tract shall require that the organization submit

1 guidelines to the agency not later than 18 months
2 after the date of enactment of this title.

3 (3) ISSUANCE.—

4 (A) IN GENERAL.—Not later than 2 years
5 after the date of the enactment of this title, the
6 Secretary shall, after notice and opportunity for
7 public comment, make a rule that provides for
8 the establishment of the guidelines submitted
9 under paragraph (2).

10 (B) LIMITATION.—The Secretary may not
11 make a rule that includes guidelines other than
12 those submitted under paragraph (2).

13 (C) DISSEMINATION.—The Secretary shall
14 post such guidelines on the public Internet web
15 page of the Department of Health and Human
16 Services.

17 (4) MAINTENANCE.—Not later than 4 years
18 after the date of enactment of this title, and every
19 2 years thereafter, the Secretary shall review the
20 guidelines and shall, as necessary, enter into con-
21 tracts similar to the contract described in paragraph
22 (2), and issue guidelines in a manner similar to the
23 issuance of guidelines under paragraph (3).

24 (b) LIMITATION ON DAMAGES.—

1 (1) LIMITATION ON NONECONOMIC DAMAGES.—

2 In any health care lawsuit, a court may not award
3 noneconomic damages with respect to treatment that
4 is consistent with a guideline issued under sub-
5 section (a).

6 (2) LIMITATION ON PUNITIVE DAMAGES.—In

7 any health care lawsuit, no punitive damages may be
8 awarded against a health care provider based on a
9 claim that such treatment caused the claimant harm
10 if—

11 (A) such treatment was subject to quality
12 review by a qualified physician consensus-build-
13 ing organization and has been found to be safe,
14 effective, and appropriate;

15 (B) such treatment was approved in a
16 guideline that underwent full review by such or-
17 ganization, public comment, approval by the
18 Secretary, and dissemination as described in
19 subparagraph (a); or

20 (C) such medical treatment is generally
21 recognized among qualified experts (including
22 medical providers and relevant physician spe-
23 cialty organizations) as safe, effective, and ap-
24 propriate.

25 (c) USE.—

1 (1) INTRODUCTION AS EVIDENCE.—Guidelines
2 established in a rule made under subsection (a) may
3 not be introduced as evidence of negligence or devi-
4 ation in the standard of care in any health care law-
5 suit unless they have previously been introduced by
6 the defendant.

7 (2) NO PRESUMPTION OF NEGLIGENCE.—There
8 shall be no presumption of negligence if a health
9 care provider provides treatment in a manner incon-
10 sistent with such guidelines.

11 (d) CONSTRUCTION.—Nothing in this section shall be
12 construed as preventing a State from—

13 (1) replacing their current medical malpractice
14 rules with rules that rely, as a defense, upon a
15 health care provider’s compliance with a guideline
16 issued under subsection (a); or

17 (2) applying additional guidelines or safe-har-
18 bors that are in addition to, but not in lieu of, the
19 guidelines issued under subsection (a).

20 **SEC. 509. STATE GRANTS TO CREATE ADMINISTRATIVE**
21 **HEALTH CARE TRIBUNALS.**

22 Part P of title III of the Public Health Service Act
23 (42 U.S.C. 280g et seq.) is amended by adding at the end
24 the following:

1 **“SEC. 399T. STATE GRANTS TO CREATE ADMINISTRATIVE**
2 **HEALTH CARE TRIBUNALS.**

3 “(a) IN GENERAL.—The Secretary may award grants
4 to States for the development, implementation, and eval-
5 uation of administrative health care tribunals that comply
6 with this section, for the resolution of disputes concerning
7 injuries allegedly caused by health care providers.

8 “(b) CONDITIONS FOR DEMONSTRATION GRANTS.—
9 To be eligible to receive a grant under this section, a State
10 shall submit to the Secretary an application at such time,
11 in such manner, and containing such information as may
12 be required by the Secretary. A grant shall be awarded
13 under this section on such terms and conditions as the
14 Secretary determines appropriate.

15 “(c) REPRESENTATION BY COUNSEL.—A State that
16 receives a grant under this section may not preclude any
17 party to a dispute before an administrative health care tri-
18 bunal operated under such grant from obtaining legal rep-
19 resentation during any review by the expert panel under
20 subsection (d), the administrative health care tribunal
21 under subsection (e), or a State court under subsection
22 (f).

23 “(d) EXPERT PANEL REVIEW AND EARLY OFFER
24 GUIDELINES.—

25 “(1) IN GENERAL.—Prior to the submission of
26 any dispute concerning injuries allegedly caused by

1 health care providers to an administrative health
2 care tribunal under this section, such allegations
3 shall first be reviewed by an expert panel.

4 “(2) COMPOSITION.—

5 “(A) IN GENERAL.—The members of each
6 expert panel under this subsection shall be ap-
7 pointed by the head of the State agency respon-
8 sible for health. Each expert panel shall be
9 composed of no fewer than 3 members and not
10 more than 7 members. At least one-half of such
11 members shall be medical experts (either physi-
12 cians or health care professionals).

13 “(B) LICENSURE AND EXPERTISE.—Each
14 physician or health care professional appointed
15 to an expert panel under subparagraph (A)
16 shall—

17 “(i) be appropriately credentialed or
18 licensed in one or more States to deliver
19 health care services; and

20 “(ii) typically treat the condition,
21 make the diagnosis, or provide the type of
22 treatment that is under review.

23 “(C) INDEPENDENCE.—

1 “(i) IN GENERAL.—Subject to clause
2 (ii), each individual appointed to an expert
3 panel under this paragraph shall—

4 “(I) not have a material familial,
5 financial, or professional relationship
6 with a party involved in the dispute
7 reviewed by the panel; and

8 “(II) not otherwise have a con-
9 flict of interest with such a party.

10 “(ii) EXCEPTION.—Nothing in clause
11 (i) shall be construed to prohibit an indi-
12 vidual who has staff privileges at an insti-
13 tution where the treatment involved in the
14 dispute was provided from serving as a
15 member of an expert panel merely on the
16 basis of such affiliation, if the affiliation is
17 disclosed to the parties and neither party
18 objects.

19 “(D) PRACTICING HEALTH CARE PROFES-
20 SIONAL IN SAME FIELD.—

21 “(i) IN GENERAL.—In a dispute be-
22 fore an expert panel that involves treat-
23 ment, or the provision of items or serv-
24 ices—

1 “(I) by a physician, the medical
2 experts on the expert panel shall be
3 practicing physicians (allopathic or os-
4 teopathic) of the same or similar spe-
5 cialty as a physician who typically
6 treats the condition, makes the diag-
7 nosis, or provides the type of treat-
8 ment under review; or

9 “(II) by a health care profes-
10 sional other than a physician, at least
11 two medical experts on the expert
12 panel shall be practicing physicians
13 (allopathic or osteopathic) of the same
14 or similar specialty as the health care
15 professional who typically treats the
16 condition, makes the diagnosis, or
17 provides the type of treatment under
18 review, and, if determined appropriate
19 by the State agency, an additional
20 medical expert shall be a practicing
21 health care professional (other than
22 such a physician) of such a same or
23 similar specialty.

24 “(ii) PRACTICING DEFINED.—In this
25 paragraph, the term ‘practicing’ means,

1 with respect to an individual who is a phy-
2 sician or other health care professional,
3 that the individual provides health care
4 services to individual patients on average
5 at least 2 days a week.

6 “(E) PEDIATRIC EXPERTISE.—In the case
7 of dispute relating to a child, at least 1 medical
8 expert on the expert panel shall have expertise
9 described in subparagraph (D)(i) in pediatrics.

10 “(3) DETERMINATION.—After a review under
11 paragraph (1), an expert panel shall make a deter-
12 mination as to the liability of the parties involved
13 and compensation.

14 “(4) ACCEPTANCE.—If the parties to a dispute
15 before an expert panel under this subsection accept
16 the determination of the expert panel concerning li-
17 ability and compensation, such compensation shall
18 be paid to the claimant and the claimant shall agree
19 to forgo any further action against the health care
20 providers involved.

21 “(5) FAILURE TO ACCEPT.—If any party de-
22 cides not to accept the expert panel’s determination,
23 the matter shall be referred to an administrative
24 health care tribunal created pursuant to this section.

25 “(e) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

1 “(1) IN GENERAL.—Upon the failure of any
2 party to accept the determination of an expert panel
3 under subsection (d), the parties shall have the right
4 to request a hearing concerning the liability or com-
5 pensation involved by an administrative health care
6 tribunal established by the State involved.

7 “(2) REQUIREMENTS.—In establishing an ad-
8 ministrative health care tribunal under this section,
9 a State shall—

10 “(A) ensure that such tribunals are pre-
11 sided over by special judges with health care ex-
12 pertise;

13 “(B) provide authority to such judges to
14 make binding rulings, rendered in written deci-
15 sions, on standards of care, causation, com-
16 pensation, and related issues with reliance on
17 independent expert witnesses commissioned by
18 the tribunal;

19 “(C) establish gross negligence as the legal
20 standard for the tribunal;

21 “(D) allow the admission into evidence of
22 the recommendation made by the expert panel
23 under subsection (d); and

24 “(E) provide for an appeals process to
25 allow for review of decisions by State courts.

1 “(f) REVIEW BY STATE COURT AFTER EXHAUSTION
2 OF ADMINISTRATIVE REMEDIES.—

3 “(1) RIGHT TO FILE.—If any party to a dispute
4 before a health care tribunal under subsection (e) is
5 not satisfied with the determinations of the tribunal,
6 the party shall have the right to file their claim in
7 a State court of competent jurisdiction.

8 “(2) FORFEIT OF AWARDS.—Any party filing
9 an action in a State court in accordance with para-
10 graph (1) shall forfeit any compensation award
11 made under subsection (e).

12 “(3) ADMISSIBILITY.—The determinations of
13 the expert panel and the administrative health care
14 tribunal pursuant to subsections (d) and (e) with re-
15 spect to a State court proceeding under paragraph
16 (1) shall be admissible into evidence in any such
17 State court proceeding.

18 “(g) DEFINITION.—In this section, the term ‘health
19 care provider’ means any person or entity required by
20 State or Federal laws or regulations to be licensed, reg-
21 istered, or certified to provide health care services, and
22 being either so licensed, registered, or certified, or exempt-
23 ed from such requirement by other statute or regulation.

24 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
25 are authorized to be appropriated for any fiscal year such

1 sums as may be necessary for purposes of making grants
2 to States under this section.”.

3 **SEC. 510. AUTHORIZATION OF PAYMENT OF FUTURE DAM-**
4 **AGES TO CLAIMANTS IN HEALTH CARE LAW-**
5 **SUITS.**

6 (a) IN GENERAL.—In any health care lawsuit, if an
7 award of future damages, without reduction to present
8 value, equaling or exceeding \$50,000 is made against a
9 party with sufficient insurance or other assets to fund a
10 periodic payment of such a judgment, the court shall, at
11 the request of any party, enter a judgment ordering that
12 the future damages be paid by periodic payments, in ac-
13 cordance with the Uniform Periodic Payment of Judg-
14 ments Act promulgated by the National Conference of
15 Commissioners on Uniform State Laws.

16 (b) APPLICABILITY.—This section applies to all ac-
17 tions which have not been first set for trial or retrial be-
18 fore the effective date of this title.

19 **SEC. 511. DEFINITIONS.**

20 In this title:

21 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
22 TEM; ADR.—The term “alternative dispute resolution
23 system” or “ADR” means a system that provides
24 for the resolution of health care lawsuits in a man-

1 ner other than through a civil action brought in a
2 State or Federal court.

3 (2) CLAIMANT.—The term “claimant” means
4 any person who brings a health care lawsuit, includ-
5 ing a person who asserts or claims a right to legal
6 or equitable contribution, indemnity, or subrogation,
7 arising out of a health care liability claim or action,
8 and any person on whose behalf such a claim is as-
9 serted or such an action is brought, whether de-
10 ceased, incompetent, or a minor.

11 (3) COLLATERAL SOURCE BENEFITS.—The
12 term “collateral source benefits” means any amount
13 paid or reasonably likely to be paid in the future to
14 or on behalf of the claimant, or any service, product,
15 or other benefit provided or reasonably likely to be
16 provided in the future to or on behalf of the claim-
17 ant, as a result of the injury or wrongful death, pur-
18 suant to—

19 (A) any State or Federal health, sickness,
20 income-disability, accident, or workers’ com-
21 pensation law;

22 (B) any health, sickness, income-disability,
23 or accident insurance that provides health bene-
24 fits or income-disability coverage;

1 (C) any contract or agreement of any
2 group, organization, partnership, or corporation
3 to provide, pay for, or reimburse the cost of
4 medical, hospital, dental, or income-disability
5 benefits; and

6 (D) any other publicly or privately funded
7 program.

8 (4) COMPENSATORY DAMAGES.—The term
9 “compensatory damages” means objectively
10 verifiable monetary losses incurred as a result of the
11 provision of, use of, or payment for (or failure to
12 provide, use, or pay for) health care services or med-
13 ical products, such as past and future medical ex-
14 penses, loss of past and future earnings, cost of ob-
15 taining domestic services, loss of employment, and
16 loss of business or employment opportunities, dam-
17 ages for physical and emotional pain, suffering, in-
18 convenience, physical impairment, mental anguish,
19 disfigurement, loss of enjoyment of life, loss of soci-
20 ety and companionship, loss of consortium (other
21 than loss of domestic service), hedonic damages, in-
22 jury to reputation, and all other nonpecuniary losses
23 of any kind or nature. The term “compensatory
24 damages” includes economic damages and non-

1 economic damages, as such terms are defined in this
2 section.

3 (5) CONTINGENT FEE.—The term “contingent
4 fee” includes all compensation to any person or per-
5 sons which is payable only if a recovery is effected
6 on behalf of one or more claimants.

7 (6) ECONOMIC DAMAGES.—The term “economic
8 damages” means objectively verifiable monetary
9 losses incurred as a result of the provision of, use
10 of, or payment for (or failure to provide, use, or pay
11 for) health care services or medical products, such as
12 past and future medical expenses, loss of past and
13 future earnings, cost of obtaining domestic services,
14 loss of employment, and loss of business or employ-
15 ment opportunities.

16 (7) FEDERAL TAX BENEFIT.—A claimant shall
17 be treated as receiving a Federal tax benefit with re-
18 spect to payment for items or services if—

19 (A) such payment is compensation by in-
20 surance—

21 (i) which constitutes medical care, and

22 (ii) with respect to the payment of
23 premiums for which the claimant, or the
24 employer of the claimant, was allowed an
25 exclusion from gross income, a deduction,

1 or a credit for Federal income tax pur-
2 poses,

3 (B) a deduction was allowed with respect
4 to such payment for Federal income tax pur-
5 poses, or

6 (C) such payment was from an Archer
7 MSA (as defined in section 220(d) of the Inter-
8 nal Revenue Code of 1986), a health savings
9 account (as defined in section 223(d) of such
10 Code), a flexible spending arrangement (as de-
11 fined in section 106(e)(2) of such Code), or a
12 health reimbursement arrangement which is
13 treated as employer-provided coverage under an
14 accident or health plan for purposes of section
15 106 of such Code.

16 (8) HEALTH CARE LAWSUIT.—The term
17 “health care lawsuit” means any health care liability
18 claim concerning the provision of health care goods
19 or services brought in a Federal court or in a State
20 court or pursuant to an alternative dispute resolu-
21 tion system, if such claim concerns items or services
22 with respect to which payment is made under title
23 XVIII, title XIX, or title XXI of the Social Security
24 Act or for which the claimant receives a Federal tax
25 benefit, against a health care provider, a health care

1 organization, or the manufacturer, distributor, sup-
2 plier, marketer, promoter, or seller of a medical
3 product, regardless of the theory of liability on which
4 the claim is based, or the number of claimants,
5 plaintiffs, defendants, or other parties, or the num-
6 ber of claims or causes of action, in which the claim-
7 ant alleges a health care liability claim. Such term
8 does not include a claim or action which is based on
9 criminal liability; which seeks civil fines or penalties
10 paid to Federal government; or which is grounded in
11 antitrust.

12 (9) HEALTH CARE LIABILITY ACTION.—The
13 term “health care liability action” means a civil ac-
14 tion brought in a State or Federal court or pursuant
15 to an alternative dispute resolution system, against
16 a health care provider, a health care organization, or
17 the manufacturer, distributor, supplier, marketer,
18 promoter, or seller of a medical product, regardless
19 of the theory of liability on which the claim is based,
20 or the number of plaintiffs, defendants, or other par-
21 ties, or the number of causes of action, in which the
22 claimant alleges a health care liability claim.

23 (10) HEALTH CARE LIABILITY CLAIM.—The
24 term “health care liability claim” means a demand
25 by any person, whether or not pursuant to ADR,

1 against a health care provider, health care organiza-
2 tion, or the manufacturer, distributor, supplier, mar-
3 keter, promoter, or seller of a medical product, in-
4 cluding, but not limited to, third-party claims, cross-
5 claims, counter-claims, or contribution claims, which
6 are based upon the provision of, use of, or payment
7 for (or the failure to provide, use, or pay for) health
8 care services or medical products, regardless of the
9 theory of liability on which the claim is based, or the
10 number of plaintiffs, defendants, or other parties, or
11 the number of causes of action.

12 (11) HEALTH CARE ORGANIZATION.—The term
13 “health care organization” means any person or en-
14 tity which is obligated to provide or pay for health
15 benefits under any health plan, including any person
16 or entity acting under a contract or arrangement
17 with a health care organization to provide or admin-
18 ister any health benefit.

19 (12) HEALTH CARE PROVIDER.—The term
20 “health care provider” means any person or entity
21 required by State or Federal laws or regulations to
22 be licensed, registered, or certified to provide health
23 care services, and being either so licensed, reg-
24 istered, or certified, or exempted from such require-
25 ment by other statute or regulation.

1 (13) HEALTH CARE GOODS OR SERVICES.—The
2 term “health care goods or services” means any
3 goods or services provided by a health care organiza-
4 tion, provider, or by any individual working under
5 the supervision of a health care provider, that relates
6 to the diagnosis, prevention, or treatment of any
7 human disease or impairment, or the assessment or
8 care of the health of human beings.

9 (14) MALICIOUS INTENT TO INJURE.—The
10 term “malicious intent to injure” means inten-
11 tionally causing or attempting to cause physical in-
12 jury other than providing health care goods or serv-
13 ices.

14 (15) MEDICAL PRODUCT.—The term “medical
15 product” means a drug, device, or biological product
16 intended for humans, and the terms “drug”, “de-
17 vice”, and “biological product” have the meanings
18 given such terms in sections 201(g)(1) and 201(h)
19 of the Federal Food, Drug and Cosmetic Act (21
20 U.S.C. 321(g)(1) and (h)) and section 351(a) of the
21 Public Health Service Act (42 U.S.C. 262(a)), re-
22 spectively, including any component or raw material
23 used therein, but excluding health care services.

24 (16) MEDICAL TREATMENT.—The term “med-
25 ical treatment” means the provision of any goods or

1 services by a health care provider or by any indi-
2 vidual working under the supervision of a health
3 care provider, that relates to the diagnosis, preven-
4 tion, or treatment of any human disease or impair-
5 ment, or the assessment or care of the health of
6 human beings.

7 (17) NONECONOMIC DAMAGES.—The term
8 “noneconomic damages” means damages for losses
9 for physical and emotional pain, suffering, inconven-
10 ience, physical impairment, mental anguish, dis-
11 figurement, loss of enjoyment of life, loss of society
12 and companionship, loss of consortium, hedonic
13 damages, injury to reputation, and any other non-
14 pecuniary losses.

15 (18) PUNITIVE DAMAGES.—The term “punitive
16 damages” means damages awarded, for the purpose
17 of punishment or deterrence, and not solely for com-
18 pensatory purposes, against a health care provider,
19 health care organization, or a manufacturer, dis-
20 tributor, or supplier of a medical product. Punitive
21 damages are neither economic nor noneconomic
22 damages.

23 (19) RECOVERY.—The term “recovery” means
24 the net sum recovered after deducting any disburse-
25 ments or costs incurred in connection with prosecu-

1 tion or settlement of the claim, including all costs
2 paid or advanced by any person. Costs of health care
3 incurred by the plaintiff and the attorneys' office
4 overhead costs or charges for legal services are not
5 deductible disbursements or costs for such purpose.

6 (20) STATE.—The term “State” means each of
7 the several States, the District of Columbia, the
8 Commonwealth of Puerto Rico, the Virgin Islands,
9 Guam, American Samoa, the Northern Mariana Is-
10 lands, the Trust Territory of the Pacific Islands, and
11 any other territory or possession of the United
12 States, or any political subdivision thereof.

13 **SEC. 512. EFFECT ON OTHER LAWS.**

14 (a) VACCINE INJURY.—

15 (1) To the extent that title XXI of the Public
16 Health Service Act establishes a Federal rule of law
17 applicable to a civil action brought for a vaccine-re-
18 lated injury or death—

19 (A) this title does not affect the application
20 of the rule of law to such an action; and

21 (B) any rule of law prescribed by this title
22 in conflict with a rule of law of such title XXI
23 shall not apply to such action.

24 (2) If there is an aspect of a civil action
25 brought for a vaccine-related injury or death to

1 which a Federal rule of law under title XXI of the
2 Public Health Service Act does not apply, then this
3 title or otherwise applicable law (as determined
4 under this title) will apply to such aspect of such ac-
5 tion.

6 (b) OTHER FEDERAL LAW.—Except as provided in
7 this section, nothing in this title shall be deemed to affect
8 any defense available to a defendant in a health care law-
9 suit or action under any other provision of Federal law.

10 **SEC. 513. STATE FLEXIBILITY AND PROTECTION OF**
11 **STATES' RIGHTS.**

12 (a) HEALTH CARE LAWSUITS.—The provisions gov-
13 erning health care lawsuits set forth in this title preempt,
14 subject to subsections (b) and (c), State law to the extent
15 that State law prevents the application of any provisions
16 of law established by or under this title. The provisions
17 governing health care lawsuits set forth in this title super-
18 sede chapter 171 of title 28, United States Code, to the
19 extent that such chapter—

20 (1) provides for a greater amount of damages
21 or contingent fees, a longer period in which a health
22 care lawsuit may be commenced, or a reduced appli-
23 cability or scope of periodic payment of future dam-
24 ages, than provided in this title; or

1 (2) prohibits the introduction of evidence re-
2 garding collateral source benefits, or mandates or
3 permits subrogation or a lien on collateral source
4 benefits.

5 (b) PROTECTION OF STATES' RIGHTS AND OTHER
6 LAWS.—(1) Any issue that is not governed by any provi-
7 sion of law established by or under this title (including
8 State standards of negligence) shall be governed by other-
9 wise applicable State or Federal law.

10 (2) This title shall not preempt or supersede any
11 State or Federal law that imposes greater procedural or
12 substantive protections for health care providers and
13 health care organizations from liability, loss, or damages
14 than those provided by this title or create a cause of ac-
15 tion.

16 (c) STATE FLEXIBILITY.—No provision of this title
17 shall be construed to preempt—

18 (1) any State law (whether effective before, on,
19 or after the date of the enactment of this title) that
20 specifies a particular monetary amount of compen-
21 satory or punitive damages (or the total amount of
22 damages) that may be awarded in a health care law-
23 suit, regardless of whether such monetary amount is
24 greater or lesser than is provided for under this title,
25 notwithstanding section 4(a); or

1 (2) any defense available to a party in a health
2 care lawsuit under any other provision of State or
3 Federal law.

4 **SEC. 514. APPLICABILITY; EFFECTIVE DATE.**

5 This title shall apply to any health care lawsuit
6 brought in a Federal or State court, or subject to an alter-
7 native dispute resolution system, that is initiated on or
8 after the date of the enactment of this title, except that
9 any health care lawsuit arising from an injury occurring
10 prior to the date of the enactment of this title shall be
11 governed by the applicable statute of limitations provisions
12 in effect at the time the injury occurred.

13 **TITLE VI—WELLNESS AND**
14 **PREVENTION**

15 **SEC. 601. PROVIDING FINANCIAL INCENTIVES FOR TREAT-**
16 **MENT COMPLIANCE.**

17 (a) LIMITATION ON EXCEPTION FOR WELLNESS
18 PROGRAMS UNDER HIPAA DISCRIMINATION RULES.—

19 (1) ERISA AMENDMENT.—Section 702(b)(2) of
20 the Employee Retirement Income Security Act of
21 1974 (29 U.S.C. 1182(b)(2)) is amended by adding
22 after and below subparagraph (B) the following:
23 “In applying subparagraph (B), a group health plan
24 (or a health insurance issuer with respect to health
25 insurance coverage) may vary premiums and cost-

1 sharing by up to 50 percent of the value of the bene-
2 fits under the plan (or coverage) based on partici-
3 pation (or lack of participation) in a standards-based
4 wellness program.”.

5 (2) PHSA AMENDMENT.—Section 2702(b)(2)
6 of the Public Health Service Act (42 U.S.C. 300gg-
7 1(b)(2)) is amended by adding after and below sub-
8 paragraph (B) the following:

9 “In applying subparagraph (B), a group health plan
10 (or a health insurance issuer with respect to health
11 insurance coverage) may vary premiums and cost-
12 sharing by up to 50 percent of the value of the bene-
13 fits under the plan (or coverage) based on partici-
14 pation (or lack of participation) in a standards-based
15 wellness program.”.

16 (3) IRC AMENDMENT.—Section 9802(b)(2) of
17 the Internal Revenue Code of 1986 is amended by
18 adding after and below subparagraph (B) the fol-
19 lowing:

20 “In applying subparagraph (B), a group health plan
21 may vary premiums and cost-sharing by up to 50
22 percent of the value of the benefits under the plan
23 based on participation (or lack of participation) in a
24 standards-based wellness program.”.

1 (b) EFFECTIVE DATE.—The amendments made by
 2 subsection (a) shall apply to plan years beginning more
 3 than 1 year after the date of the enactment of this Act.

4 **TITLE VII—TRANSPARENCY AND**
 5 **INSURANCE REFORM MEASURES**

6 **SEC. 701. RECEIPT AND RESPONSE TO REQUESTS FOR**
 7 **CLAIM INFORMATION.**

8 (a) IN GENERAL.—Title XXVII of the Public Health
 9 Service Act is amended by inserting after section 2713 the
 10 following new section:

11 **“SEC. 2714. RECEIPT AND RESPONSE TO REQUESTS FOR**
 12 **CLAIM INFORMATION.**

13 “(a) REQUIREMENT.—

14 “(1) IN GENERAL.—In the case of health insur-
 15 ance coverage offered in connection with a group
 16 health plan, not later than the 30th day after the
 17 date a health insurance issuer receives a written re-
 18 quest for a written report of claim information from
 19 the plan, plan sponsor, or plan administrator, the
 20 health insurance issuer shall provide the requesting
 21 party the report, subject to the succeeding provisions
 22 of this section.

23 “(2) EXCEPTION.—The health insurance issuer
 24 is not obligated to provide a report under this sub-
 25 section regarding a particular employer or group

1 health plan more than twice in any 12-month period
2 and is not obligated to provide such a report in the
3 case of an employer with fewer than 50 employees.

4 “(3) DEADLINE.—A plan, plan sponsor, or plan
5 administrator must request a report under this sub-
6 section before or on the second anniversary of the
7 date of termination of coverage under a group health
8 plan issued by the health insurance issuer.

9 “(b) FORM OF REPORT; INFORMATION TO BE IN-
10 CLUDED.—

11 “(1) IN GENERAL.—A health insurance issuer
12 shall provide the report of claim information under
13 subsection (a)—

14 “(A) in a written report;

15 “(B) through an electronic file transmitted
16 by secure electronic mail or a file transfer pro-
17 tocol site; or

18 “(C) by making the required information
19 available through a secure Web site or Web por-
20 tal accessible by the requesting plan, plan spon-
21 sor, or plan administrator.

22 “(2) INFORMATION TO BE INCLUDED.—A re-
23 port of claim information provided under subsection
24 (a) shall contain all information available to the
25 health insurance issuer that is responsive to the re-

1 quest made under such subsection, including, subject
2 to subsection (c), protected health information, for
3 the 36-month period preceding the date of the report
4 or the period specified by subparagraphs (D), (E),
5 and (F) of paragraph (3), if applicable, or for the
6 entire period of coverage, whichever period is short-
7 er.

8 “(3) REQUIRED INFORMATION.—Subject to
9 subsection (c), a report provided under subsection
10 (a) shall include the following:

11 “(A) Aggregate paid claims experience by
12 month, including claims experience for medical,
13 dental, and pharmacy benefits, as applicable.

14 “(B) Total premium paid by month.

15 “(C) Total number of covered employees
16 on a monthly basis by coverage tier, including
17 whether coverage was for—

18 “(i) an employee only;

19 “(ii) an employee with dependents
20 only;

21 “(iii) an employee with a spouse only;

22 or

23 “(iv) an employee with a spouse and
24 dependents.

1 “(D) The total dollar amount of claims
2 pending as of the date of the report.

3 “(E) A separate description and individual
4 claims report for any individual whose total
5 paid claims exceed \$15,000 during the 12-
6 month period preceding the date of the report,
7 including the following information related to
8 the claims for that individual—

9 “(i) a unique identifying number,
10 characteristic, or code for the individual;

11 “(ii) the amounts paid;

12 “(iii) dates of service; and

13 “(iv) applicable procedure codes and
14 diagnosis codes.

15 “(F) For claims that are not part of the
16 information described in a previous subpara-
17 graph, a statement describing precertification
18 requests for hospital stays of 5 days or longer
19 that were made during the 30-day period pre-
20 ceding the date of the report.

21 “(c) LIMITATIONS ON DISCLOSURE.—

22 “(1) IN GENERAL.—A health insurance issuer
23 may not disclose protected health information in a
24 report of claim information provided under this sec-
25 tion if the health insurance issuer is prohibited from

1 disclosing that information under another State or
2 Federal law that imposes more stringent privacy re-
3 strictions than those imposed under Federal law
4 under the HIPAA privacy regulations. To withhold
5 information in accordance with this subsection, the
6 health insurance issuer must—

7 “(A) notify the plan, plan sponsor, or plan
8 administrator requesting the report that infor-
9 mation is being withheld; and

10 “(B) provide to the plan, plan sponsor, or
11 plan administrator a list of categories of claim
12 information that the health insurance issuer has
13 determined are subject to the more stringent
14 privacy restrictions under another State or Fed-
15 eral law.

16 “(2) PROTECTION.—A plan sponsor is entitled
17 to receive protected health information under sub-
18 paragraph (E) and (F) of subsection (b)(3) and sub-
19 section (d) only after an appropriately authorized
20 representative of the plan sponsor makes to the
21 health insurance issuer a certification substantially
22 similar to the following certification: ‘I hereby certify
23 that the plan documents comply with the require-
24 ments of section 164.504(f)(2) of title 45, Code of
25 Federal Regulations, and that the plan sponsor will

1 safeguard and limit the use and disclosure of pro-
2 tected health information that the plan sponsor may
3 receive from the group health plan to perform the
4 plan administration functions.’.

5 “(3) RESULTS.—A plan sponsor that does not
6 provide the certification required by paragraph (2) is
7 not entitled to receive the protected health informa-
8 tion described by subparagraphs (E) and (F) of sub-
9 section (b)(3) and subsection (d), but is entitled to
10 receive a report of claim information that includes
11 the information described by subparagraphs (A)
12 through (D) of subsection (b)(3).

13 “(4) INFORMATION.—In the case of a request
14 made under subsection (a) after the date of termi-
15 nation of coverage, the report must contain all infor-
16 mation available to the health insurance issuer as of
17 the date of the report that is responsive to the re-
18 quest, including protected health information, and
19 including the information described by subsection
20 (b)(3), for the period described by subsection (b)(2)
21 preceding the date of termination of coverage or for
22 the entire policy period, whichever period is shorter.
23 Notwithstanding this subsection, the report may not
24 include the protected health information described
25 by subparagraphs (E) and (F) of subsection (b)(3)

1 unless a certification has been provided in accord-
2 ance with paragraph (2).

3 “(d) REQUEST FOR ADDITIONAL INFORMATION.—

4 “(1) REVIEW.—On receipt of the report re-
5 quired by subsection (a), the plan, plan sponsor, or
6 plan administrator may review the report and, not
7 later than the 10th day after the date the report is
8 received, may make a written request to the health
9 insurance issuer for additional information in ac-
10 cordance with this subsection for specified individ-
11 uals.

12 “(2) REQUEST.—With respect to a request for
13 additional information concerning specified individ-
14 uals for whom claims information has been provided
15 under subsection (b)(3)(E), the health insurance
16 issuer shall provide additional information on the
17 prognosis or recovery if available and, for individuals
18 in active case management, the most recent case
19 management information, including any future ex-
20 pected costs and treatment plan, that relate to the
21 claims for that individual.

22 “(3) RESPONSE.—The health insurance issuer
23 must respond to the request for additional informa-
24 tion under this subsection not later than the 15th
25 day after the date of such request unless the re-

1 questing plan, plan sponsor, or plan administrator
2 agrees to a request for additional time.

3 “(4) LIMITATION.—The health insurance issuer
4 is not required to produce the report described by
5 this subsection unless a certification has been pro-
6 vided in accordance with subsection (c)(2).

7 “(5) COMPLIANCE WITH SECTION DOES NOT
8 CREATE LIABILITY.—A health insurance issuer that
9 releases information, including protected health in-
10 formation, in accordance with this subsection has
11 not violated a standard of care and is not liable for
12 civil damages resulting from, and is not subject to
13 criminal prosecution for, releasing that information.

14 “(e) LIMITATION ON PREEMPTION.—Nothing in this
15 section is meant to limit States from enacting additional
16 laws in addition to the provisions of this section, but not
17 in lieu of such provisions.

18 “(f) DEFINITIONS.—In this section:

19 “(1) The terms ‘employer’, ‘plan administrator’,
20 and ‘plan sponsor’ have the meanings given such
21 terms in section 3 of the Employee Retirement In-
22 come Security Act of 1974.

23 “(2) The term ‘HIPAA privacy regulations’ has
24 the meaning given such term in section 1180(b)(3)
25 of the Social Security Act.

1 “(3) The term ‘protected health information’
2 has the meaning given such term under the HIPAA
3 privacy regulations.”.

4 (b) EFFECTIVE DATE.—The amendment made by
5 subsection (a) shall take effect on the date of the enact-
6 ment of this Act.

7 **TITLE VIII—QUALITY**

8 **SEC. 801. PROHIBITION ON CERTAIN USES OF DATA OB-** 9 **TAINED FROM COMPARATIVE EFFECTIVE-** 10 **NESS RESEARCH; ACCOUNTING FOR PERSON-** 11 **ALIZED MEDICINE AND DIFFERENCES IN PA-** 12 **TIENT TREATMENT RESPONSE.**

13 (a) IN GENERAL.—Notwithstanding any other provi-
14 sion of law, the Secretary of Health and Human Serv-
15 ices—

16 (1) shall not use data obtained from the con-
17 duct of comparative effectiveness research, including
18 such research that is conducted or supported using
19 funds appropriated under the American Recovery
20 and Reinvestment Act of 2009 (Public Law 111–5),
21 to deny coverage of an item or service under a Fed-
22 eral health care program (as defined in section
23 1128B(f) of the Social Security Act (42 U.S.C.
24 1320a–7b(f))); and

1 title XVIII of the Social Security Act. Such proposal shall
 2 be in concert and agreement with the Physician Consor-
 3 tium for Performance Improvement and shall only utilize
 4 measures agreed upon by each physician specialty organi-
 5 zation.

6 **TITLE IX—STATE**
 7 **TRANSPARENCY PLAN PORTAL**

8 **SEC. 901. PROVIDING INFORMATION ON HEALTH COV-**
 9 **ERAGE OPTIONS AND HEALTH CARE PRO-**
 10 **VIDERS.**

11 (a) STATE-BASED PORTAL.—A State (by itself or
 12 jointly with other States) may contract with a private enti-
 13 ty to establish a Health Plan and Provider Portal Web
 14 site (referred to in this section as a “plan portal”) for
 15 the purposes of providing standardized information—

16 (1) on health insurance plans that have been
 17 certified to be available for purchase in that State;
 18 and

19 (2) on price and quality information on health
 20 care providers (including physicians, hospitals, and
 21 other health care institutions).

22 (b) PILOT PROGRAM.—

23 (1) IN GENERAL.—Not later than 90 days after
 24 the date of the enactment of this Act the Secretary
 25 of Health and Human Services shall work with

1 States to establish no later than January 1, 2013,
2 consistent with this title, a Web site that will serve
3 as a pilot program for a national portal for informa-
4 tion structured in a manner so individuals may di-
5 rectly link to the State plan portal for the State in
6 which they reside.

7 (2) CONTRACTS WITH STATE.—The Secretary
8 shall enter into contracts with States, in a number
9 and distribution determined by the Secretary, to de-
10 velop State plan portals that follow the applicable
11 standards and regulations under this section.

12 (3) COMMON STANDARDS FOR PLAN POR-
13 TALS.—

14 (A) IN GENERAL.—In connection with such
15 Web site, the Secretary shall establish stand-
16 ards for interoperability and consistency for
17 State plan portals so that individuals can access
18 and view information in a similar manner on
19 plan portals of different States. Such standards
20 shall include standard definitions for health in-
21 surance plan benefits so that individuals can ac-
22 curately compare health insurance plans within
23 such portals and standards for the inclusion of
24 information described in subsection (c).

1 (B) CONSULTATION.—The Secretary shall
2 consult with a group consisting of a balanced
3 representation of the critical stakeholders (in-
4 cluding States, health insurance issuers, the
5 National Association of Insurance Commis-
6 sioners, qualified health care provider-based en-
7 tities (including physicians, hospitals, and other
8 health care institutions), and a standards devel-
9 opment organization) to develop such stand-
10 ards.

11 (C) ISSUANCE.—

12 (i) IN GENERAL.—Not later than 6
13 months after the date of the enactment of
14 this Act, the Secretary shall issue, by regu-
15 lation, after notice and opportunity for
16 public comment, standards that are con-
17 sistent with the recommendations made by
18 the group under subparagraph (B).

19 (ii) DISSEMINATION.—The Secretary
20 shall broadly disseminate the standards so
21 issued.

22 (D) REVIEW.—One year after the date of
23 establishment of the pilot program under this
24 subsection, the Secretary, in consultation with
25 stakeholder group described in subparagraph

1 (B), shall review the standards established and
2 make such changes in such standards as may
3 be appropriate.

4 (4) AUTHORIZATION OF APPROPRIATIONS.—
5 There are authorized to be appropriated to the Sec-
6 retary such amounts as may be necessary for—

7 (A) the development and operation of the
8 national Web site under this subsection; and

9 (B) contracts with States under paragraph
10 (2) to assist in the development and initial op-
11 eration of plan portals in accordance with
12 standards established under paragraph (3) and
13 other applicable provisions of this section.

14 (c) INFORMATION IN PLAN PORTALS.—The stand-
15 ards for plan portals under subsection (b)(3) shall include
16 the following:

17 (1) HEALTH INSURANCE INFORMATION.—Each
18 plan portal shall meet the following requirements
19 with respect to information on health insurance
20 plans:

21 (A) The plan portal shall present complete
22 information on the costs and benefits of health
23 insurance plans (including information on
24 monthly premium, copayments, deductibles, and
25 covered benefits) in a uniform manner that—

1 (i) uses the standard definitions devel-
2 oped under subsection (b)(3); and

3 (ii) is designed to allow consumers to
4 easily compare such plans.

5 (B) The plan portal shall be available on
6 the internet and accessible to all individuals in
7 the United States.

8 (C) The plan portal shall allow consumers
9 to search and sort data on the health insurance
10 plans in the plan portal on criteria such as cov-
11 erage of specific benefits (such as coverage of
12 disease management services or pediatric care
13 services), as well as data available respecting
14 quality of plans.

15 (D) The plan portal shall meet all relevant
16 State laws and regulations, including laws and
17 regulations related to the marketing of insur-
18 ance products.

19 (E) Notwithstanding subsection (d)(1), the
20 plan portal shall provide information to individ-
21 uals who are eligible for the Medicaid program
22 under title XIX of the Social Security Act or
23 State Children's Health Insurance Program
24 under title XXI of such Act by including infor-
25 mation on options, eligibility, and how to enroll

1 through providing a link to a Web site main-
2 tained with respect to such State programs.

3 (F) The plan portal shall provide support
4 to individuals who are eligible for tax credits
5 and deductions under the amendments made by
6 this Act to enhance such individual's ability to
7 access such credits and deductions.

8 (G) The plan portal shall allow consumers
9 to access quality data on providers as made
10 available through a Web site described in sec-
11 tion 802 once that data is available.

12 (2) PROVIDER INFORMATION.—Each plan por-
13 tal shall meet the following requirements with re-
14 spect to information on health care providers:

15 (A) Identifying and licensure information.

16 (B) Self-pay prices charged, including vari-
17 ation in such prices.

18 For purposes of subparagraph (B), the term “self-
19 pay price” means the price charged by a provider to
20 individuals for items or services where the price is
21 not established or negotiated through a health care
22 program or third party.

23 (3) TAX CREDIT AND DEDUCTION INFORMA-
24 TION.—Each plan portal shall also include informa-

1 tion on tax credits and deductions that may be avail-
2 able for purpose of qualified health plans.

3 (4) INCLUSION OF QUALITY INFORMATION.—

4 The Secretary, after collaboration with States and
5 health care providers (including practicing physi-
6 cians, hospitals, and other health care institutions),
7 shall submit to Congress recommendations on how
8 to include on plan portals information on perform-
9 ance-based quality measures obtained under section
10 802.

11 (d) PROHIBITIONS.—

12 (1) DIRECT ENROLLMENT.—A plan portal may
13 not directly enroll individuals in health insurance
14 plans or under a State Medicaid plan or a State
15 children’s health insurance plan.

16 (2) CONFLICTS OF INTEREST.—

17 (A) COMPANIES.—A health insurance
18 issuer offering a health insurance plan through
19 a plan portal may not—

20 (i) be the private entity developing
21 and maintaining a plan portal under this
22 section; or

23 (ii) have an ownership interest in such
24 private entity or in the plan portal.

1 (B) INDIVIDUALS.—An individual em-
2 ployed by a health insurance issuer offering a
3 health insurance plan through a plan portal
4 may not serve as a director or officer for—

5 (i) the private entity developing and
6 maintaining a plan portal under this sec-
7 tion; or

8 (ii) the plan portal.

9 (e) CONSTRUCTION.—Nothing in this section shall be
10 construed to prohibit health insurance brokers and agents
11 from—

12 (1) utilizing the plan portal for any purpose; or

13 (2) marketing or offering health insurance
14 products.

15 (f) STATE DEFINED.—In this section, the term
16 “State” has the meaning given such term for purposes of
17 title XIX of the Social Security Act.

18 (g) HEALTH INSURANCE PLANS.—For purposes of
19 this section, the term “health insurance plan” does not
20 include coverage of excepted benefits, as defined in section
21 2791(c) of the Public Health Service Act (42 U.S.C.
22 300gg–91(c)).

1 **TITLE X—PATIENT FREEDOM OF**
2 **CHOICE**

3 **SEC. 1001. GUARANTEEING FREEDOM OF CHOICE AND CON-**
4 **TRACTING FOR PATIENTS UNDER MEDICARE.**

5 (a) IN GENERAL.—Section 1802 of the Social Secu-
6 rity Act (42 U.S.C. 1395a) is amended to read as follows:

7 “FREEDOM OF CHOICE AND CONTRACTING BY PATIENT
8 GUARANTEED

9 “SEC. 1802. (a) BASIC FREEDOM OF CHOICE.—Any
10 individual entitled to insurance benefits under this title
11 may obtain health services from any institution, agency,
12 or person qualified to participate under this title if such
13 institution, agency, or person undertakes to provide that
14 individual such services.

15 “(b) FREEDOM TO CONTRACT BY MEDICARE BENE-
16 FICIARIES.—

17 “(1) IN GENERAL.—Subject to the provisions of
18 this subsection, nothing in this title shall prohibit a
19 Medicare beneficiary from entering into a contract
20 with an eligible professional (whether or not the pro-
21 fessional is a participating or non-participating phy-
22 sician or practitioner) for any item or service cov-
23 ered under this title.

24 “(2) SUBMISSION OF CLAIMS.—Any Medicare
25 beneficiary that enters into a contract under this

1 section with an eligible professional shall be per-
2 mitted to submit a claim for payment under this
3 title for services furnished by such professional, and
4 such payment shall be made in the amount that
5 would otherwise apply to such professional under
6 this title except that where such professional is con-
7 sidered to be non-participating, payment shall be
8 paid as if the professional were participating. Pay-
9 ment made under this title for any item or service
10 provided under the contract shall not render the pro-
11 fessional a participating or non-participating physi-
12 cian or practitioner, and as such, requirements of
13 this title that may otherwise apply to a participating
14 or non-participating physician or practitioner would
15 not apply with respect to any items or services fur-
16 nished under the contract.

17 “(3) BENEFICIARY PROTECTIONS.—

18 “(A) IN GENERAL.—Paragraph (1) shall
19 not apply to any contract unless—

20 “(i) the contract is in writing, is
21 signed by the Medicare beneficiary and the
22 eligible professional, and establishes all
23 terms of the contract (including specific
24 payment for items and services covered by
25 the contract) before any item or service is

1 provided pursuant to the contract, and the
2 beneficiary shall be held harmless for any
3 subsequent payment charged for an item
4 or service in excess of the amount estab-
5 lished under the contract during the period
6 the contract is in effect;

7 “(ii) the contract contains the items
8 described in subparagraph (B); and

9 “(iii) the contract is not entered into
10 at a time when the Medicare beneficiary is
11 facing an emergency medical condition or
12 urgent health care situation.

13 “(B) ITEMS REQUIRED TO BE INCLUDED
14 IN CONTRACT.—Any contract to provide items
15 and services to which paragraph (1) applies
16 shall clearly indicate to the Medicare beneficiary
17 that by signing such contract the beneficiary—

18 “(i) agrees to be responsible for pay-
19 ment to such eligible professional for such
20 items or services under the terms of and
21 amounts established under the contract;

22 “(ii) agrees to be responsible for sub-
23 mitting claims under this title to the Sec-
24 retary, and to any other supplemental in-
25 surance plan that may provide supple-

1 mental insurance, for such items or serv-
2 ices furnished under the contract if such
3 items or services are covered by this title,
4 unless otherwise provided in the contract
5 under subparagraph (C)(i); and

6 “(iii) acknowledges that no limits or
7 other payment incentives that may other-
8 wise apply under this title (such as the
9 limits under subsection (g) of section 1848
10 or incentives under subsection (a)(5), (m),
11 (q), and (p) of such section) shall apply to
12 amounts that may be charged, or paid to
13 a beneficiary for, such items or services.

14 Such contract shall also clearly indicate whether
15 the eligible professional is excluded from par-
16 ticipation under the Medicare program under
17 section 1128.

18 “(C) BENEFICIARY ELECTIONS UNDER
19 THE CONTRACT.—Any Medicare beneficiary
20 that enters into a contract under this section
21 may elect to negotiate, as a term of the con-
22 tract, a provision under which—

23 “(i) the eligible professional shall file
24 claims on behalf of the beneficiary with the
25 Secretary and any supplemental insurance

1 plan for items or services furnished under
2 the contract if such items or services are
3 covered under this title or under the plan;
4 and

5 “(ii) the beneficiary assigns payment
6 to the eligible professional for any claims
7 filed by, or on behalf of, the beneficiary
8 with the Secretary and any supplemental
9 insurance plan for items or services fur-
10 nished under the contract.

11 “(D) EXCLUSION OF DUAL ELIGIBLE INDI-
12 VIDUALS.—Paragraph (1) shall not apply to
13 any contract if a beneficiary who is eligible for
14 medical assistance under title XIX is a party to
15 the contract.

16 “(4) LIMITATION ON ACTUAL CHARGE AND
17 CLAIM SUBMISSION REQUIREMENT NOT APPLICA-
18 BLE.—Section 1848(g) shall not apply with respect
19 to any item or service provided to a Medicare bene-
20 ficiary under a contract described in paragraph (1).

21 “(5) CONSTRUCTION.—Nothing in this section
22 shall be construed—

23 “(A) to prohibit any eligible professional
24 from maintaining an election and acting as a
25 participating or non-participating physician or

1 practitioner with respect to any patient not cov-
2 ered under a contract established under this
3 section; and

4 “(B) as changing the items and services
5 for which an eligible professional may bill under
6 this title.

7 “(6) DEFINITIONS.—In this subsection:

8 “(A) MEDICARE BENEFICIARY.—The term
9 ‘Medicare beneficiary’ means an individual who
10 is entitled to benefits under part A or enrolled
11 under part B.

12 “(B) ELIGIBLE PROFESSIONAL.—The term
13 ‘eligible professional’ has the meaning given
14 such term in section 1848(k)(3)(B).

15 “(C) EMERGENCY MEDICAL CONDITION.—
16 The term ‘emergency medical condition’ means
17 a medical condition manifesting itself by acute
18 symptoms of sufficient severity (including se-
19 vere pain) such that a prudent layperson, with
20 an average knowledge of health and medicine,
21 could reasonably expect the absence of imme-
22 diate medical attention to result in—

23 “(i) serious jeopardy to the health of
24 the individual or, in the case of a pregnant

1 woman, the health of the woman or her
2 unborn child;

3 “(ii) serious impairment to bodily
4 functions; or

5 “(iii) serious dysfunction of any bodily
6 organ or part.

7 “(D) URGENT HEALTH CARE SITUA-
8 TION.—The term ‘urgent health care situation’
9 means services furnished to an individual who
10 requires services to be furnished within 12
11 hours in order to avoid the likely onset of an
12 emergency medical condition.”.

13 **SEC. 1002. PREEMPTION OF STATE LAWS LIMITING**
14 **CHARGES FOR ELIGIBLE PROFESSIONAL**
15 **SERVICES.**

16 (a) IN GENERAL.—No State may impose a limit on
17 the amount of charges for services, furnished by an eligible
18 professional (as defined in subsection (k)(3)(B) of section
19 1848 of the Social Security Act, 42 U.S.C. 1395w-4), for
20 which payment is made under such section, and any such
21 limit is hereby preempted.

22 (b) STATE.—In this section, the term “State” in-
23 cludes the District of Columbia, Puerto Rico, the Virgin
24 Islands, Guam, and American Samoa.

1 **SEC. 1003. HEALTH CARE PROVIDER LICENSURE CANNOT**
2 **BE CONDITIONED ON PARTICIPATION IN A**
3 **HEALTH PLAN.**

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services and any State (as a condition of receiving
6 Federal financial participation under title XIX of the So-
7 cial Security Act) may not require any health care pro-
8 vider to participate in any health plan as a condition of
9 licensure of the provider in any State.

10 (b) DEFINITIONS.—In this section:

11 (1) HEALTH PLAN.—The term “health plan”
12 has the meaning given such term in section 1171(5)
13 of the Social Security Act (42 U.S.C. 1320d(5)).

14 (2) HEALTH CARE PROVIDER.—The term
15 “health care provider” means any person or entity
16 that is required by State or Federal laws or regula-
17 tions to be licensed, registered, or certified to pro-
18 vide health care services and is so licensed, reg-
19 istered, or certified, or exempted from such require-
20 ment by other statute or regulation.

21 (3) STATE.—The term “State” has the mean-
22 ing given such term for purposes of title XIX of the
23 Social Security Act.

1 **SEC. 1004. BAD DEBT DEDUCTION FOR DOCTORS TO PAR-**
2 **TIALLY OFFSET THE COST OF PROVIDING UN-**
3 **COMPENSATED CARE REQUIRED TO BE PRO-**
4 **VIDED UNDER AMENDMENTS MADE BY THE**
5 **EMERGENCY MEDICAL TREATMENT AND**
6 **LABOR ACT.**

7 (a) IN GENERAL.—Section 166 of the Internal Rev-
8 enue Code of 1986 (relating to bad debts) is amended by
9 redesignating subsection (f) as subsection (g) and by in-
10 serting after subsection (e) the following new subsection:

11 “(f) BAD DEBT TREATMENT FOR DOCTORS TO PAR-
12 Tially OFFSET COST OF PROVIDING UNCOMPENSATED
13 CARE REQUIRED TO BE PROVIDED.—

14 “(1) AMOUNT OF DEDUCTION.—

15 “(A) IN GENERAL.—For purposes of sub-
16 section (a), the basis for determining the
17 amount of any deduction for an eligible
18 EMTALA debt shall be treated as being equal
19 to the Medicare payment amount.

20 “(B) MEDICARE PAYMENT AMOUNT.—For
21 purposes of subparagraph (A), the Medicare
22 payment amount with respect to an eligible
23 EMTALA debt is the fee schedule amount es-
24 tablished under section 1848 of the Social Secu-
25 rity Act for the physicians’ service (to which
26 such debt relates) as if the service were pro-

1 vided to an individual enrolled under part B of
2 title XVIII of such Act.

3 “(2) ELIGIBLE EMTALA DEBT.—For purposes
4 of this section, the term ‘eligible EMTALA debt’
5 means any debt if—

6 “(A) such debt arose as a result of physi-
7 cians’ services—

8 “(i) which were performed in an
9 EMTALA hospital by a board-certified
10 physician (whether as part of medical
11 screening or necessary stabilizing treat-
12 ment and whether as an emergency depart-
13 ment physician, as an on-call physician, or
14 otherwise), and

15 “(ii) which were required to be pro-
16 vided under section 1867 of the Social Se-
17 curity Act (42 U.S.C. 1395dd), and

18 “(B) such debt is owed—

19 “(i) to such physician, or

20 “(ii) to an entity if—

21 “(I) such entity is a corporation
22 and the sole shareholder of such cor-
23 poration is such physician, or

24 “(II) such entity is a partnership
25 and any deduction under this sub-

1 section with respect to such debt is al-
2 located to such physician or to an en-
3 tity described in subclause (I).

4 “(3) BOARD-CERTIFIED PHYSICIAN.—For pur-
5 poses of this subsection, the term ‘board-certified
6 physician’ means any physician (as defined in sec-
7 tion 1861(r) of the Social Security Act (42 U.S.C.
8 1395x(r)) who is certified by the American Board of
9 Emergency Medicine or other appropriate medical
10 specialty board for the specialty in which the physi-
11 cian practices, or who meets comparable require-
12 ments, as identified by the Secretary of the Treasury
13 in consultation with Secretary of Health and Human
14 Services.

15 “(4) OTHER DEFINITIONS.—For purposes of
16 this subsection—

17 “(A) EMTALA HOSPITAL.—The term
18 ‘EMTALA hospital’ means any hospital having
19 a hospital emergency department which is re-
20 quired to comply with section 1867 of the So-
21 cial Security Act (42 U.S.C. 1395dd) (relating
22 to examination and treatment for emergency
23 medical conditions and women in labor).

24 “(B) PHYSICIANS’ SERVICES.—The term
25 ‘physicians’ services’ has the meaning given

1 (2) EXCLUSION OF MEDICAID AND TRICARE.—

2 Such term does not include a health plan partici-
3 pating in—

4 (A) the Medicaid program under title XIX
5 of the Social Security Act; or

6 (B) the TRICARE program under chapter
7 55 of title 10, United States Code.

8 (c) HEALTH CARE PROVIDER DEFINED.—In this
9 section, the term “health care provider” means—

10 (1) a physician, as defined in paragraphs (1),
11 (2), (3), and (4) of section 1861(r) of the Social Se-
12 curity Act (42 U.S.C. 1395x(r)); and

13 (2) a health care practitioner described in sec-
14 tion 1842(b)(18)(C) of such Act (42 U.S.C.
15 1395u(b)(18)(C)).

16 **TITLE XI—INCENTIVES TO**
17 **REDUCE PHYSICIAN SHORTAGES**
18 **Subtitle A—Federally Supported**
19 **Student Loan Funds for Medical**
20 **Students**

21 **SEC. 1101. FEDERALLY SUPPORTED STUDENT LOAN FUNDS**
22 **FOR MEDICAL STUDENTS.**

23 (a) PRIMARY HEALTH CARE MEDICAL STUDENTS.—
24 Subpart II of part A of the Public Health Service Act (42
25 U.S.C. 292q et seq.) is amended—

1 (1) by redesignating section 735 as section 729;
2 and

3 (2) in subsection (f) of section 729 (as so redesi-
4 gnated), by striking “is authorized to be appro-
5 priated \$10,000,000 for each of the fiscal years
6 1994 through 1996” and inserting “are authorized
7 to be appropriated such sums as may be necessary
8 for fiscal year 2012 and each fiscal year thereafter”.

9 (b) OTHER MEDICAL STUDENTS.—Part A of title VII
10 of the Public Health Service Act (42 U.S.C. 292 et seq.)
11 is amended by adding at the end the following:

12 **“Subpart III—Federally Supported Student Loan**

13 **Funds for Certain Medical Students**

14 **“SEC. 730. SCHOOL LOAN FUNDS FOR CERTAIN MEDICAL**
15 **STUDENTS.**

16 “(a) FUND AGREEMENTS.—For the purpose de-
17 scribed in subsection (b), the Secretary is authorized to
18 enter into an agreement for the establishment and oper-
19 ation of a student loan fund with any public or nonprofit
20 school of medicine or osteopathic medicine.

21 “(b) PURPOSE.—The purpose of this subpart is to
22 provide for loans to medical students who would be eligible
23 for a loan under subpart II, except for the student’s deci-
24 sion to enter a residency training program in a field other
25 than primary health care.

1 “(c) COMMENCEMENT OF REPAYMENT PERIOD.—

2 The repayment period for a loan under this section shall
3 not begin before the end of any period during which the
4 student is participating in an internship, residency, or fel-
5 lowship training program directly related to the field of
6 medicine which the student agrees to enter pursuant to
7 subsection (d).

8 “(d) REQUIREMENTS FOR STUDENTS.—Each agree-
9 ment under this section for the establishment of a student
10 loan fund shall provide that the school of medicine or os-
11 teopathic medicine will make a loan to a student from such
12 fund only if the student agrees—

13 “(1) to enter and complete a residency training
14 program (in a field of medicine other than primary
15 health care) not later than a period determined by
16 the Secretary to be reasonable after the date on
17 which the student graduates from such school; and

18 “(2) to practice medicine through the date on
19 which the loan is repaid in full.

20 “(e) REQUIREMENTS FOR SCHOOLS.—The provisions
21 of section 723(b) (regarding graduates in primary health
22 care) shall not apply to a student loan fund established
23 under this section.

24 “(f) APPLICABILITY OF OTHER PROVISIONS.—Ex-
25 cept as inconsistent with this section, the provisions of

1 subpart II shall apply to the program of student loan
2 funds established under this section to the same extent
3 and in the same manner as such provisions apply to the
4 program of student loan funds established under subpart
5 II.

6 “(g) AUTHORIZATION OF APPROPRIATIONS.—To
7 carry out this section, there are authorized to be appro-
8 priated such sums as may be necessary for fiscal year
9 2012 and each fiscal year thereafter.”.

10 **Subtitle B—Loan Forgiveness for** 11 **Primary Care Providers**

12 **SEC. 1111. LOAN FORGIVENESS FOR PRIMARY CARE PRO-** 13 **VIDERS.**

14 (a) IN GENERAL.—The Secretary of Health and
15 Human Services shall carry out a program of entering into
16 contracts with eligible individuals under which—

17 (1) the individual agrees to serve for a period
18 of not less than 5 years as a primary care provider;
19 and

20 (2) in consideration of such service, the Sec-
21 retary agrees to pay not more than \$50,000 on the
22 principal and interest on the individual’s graduate
23 educational loans.

24 (b) ELIGIBILITY.—To be eligible to enter into a con-
25 tract under subsection (a), an individual must—

1 (1) have a graduate degree in medicine, osteo-
2 pathic medicine, or another health profession from
3 an accredited (as determined by the Secretary of
4 Health and Human Services) institution of higher
5 education; and

6 (2) have practiced as a primary care provider
7 for a period (excluding any residency or fellowship
8 training period) of not less than—

9 (A) 5 years; or

10 (B) 3 years in a medically underserved
11 community (as defined in section 799B of the
12 Public Health Service Act (42 U.S.C. 295p)).

13 (c) INSTALLMENTS.—Payments under this section
14 may be made in installments of not more than \$10,000
15 for each year of service described in subsection (a)(1).

16 (d) APPLICABILITY OF CERTAIN PROVISIONS.—The
17 provisions of subpart III of part D of title III of the Public
18 Health Service Act shall, except as inconsistent with this
19 section, apply to the program established under this sec-
20 tion in the same manner and to the same extent as such
21 provisions apply to the National Health Service Corps
22 Loan Repayment Program established in such subpart.

1 **TITLE XII—QUALITY HEALTH**
2 **CARE COALITION**

3 **SEC. 1201. QUALITY HEALTH CARE COALITION.**

4 (a) APPLICATION OF THE FEDERAL ANTITRUST
5 LAWS TO HEALTH CARE PROFESSIONALS NEGOTIATING
6 WITH HEALTH PLANS.—

7 (1) IN GENERAL.—Any health care profes-
8 sionals who are engaged in negotiations with a
9 health plan regarding the terms of any contract
10 under which the professionals provide health care
11 items or services for which benefits are provided
12 under such plan shall, in connection with such nego-
13 tiations, be exempt from the Federal antitrust laws.

14 (2) LIMITATION.—

15 (A) NO NEW RIGHT FOR COLLECTIVE CES-
16 SATION OF SERVICE.—The exemption provided
17 in paragraph (1) shall not confer any new right
18 to participate in any collective cessation of serv-
19 ice to patients not already permitted by existing
20 law.

21 (B) NO CHANGE IN NATIONAL LABOR RE-
22 LATIONS ACT.—This section applies only to
23 health care professionals excluded from the Na-
24 tional Labor Relations Act. Nothing in this sec-
25 tion shall be construed as changing or amend-

1 ing any provision of the National Labor Rela-
2 tions Act, or as affecting the status of any
3 group of persons under that Act.

4 (3) NO APPLICATION TO FEDERAL PRO-
5 GRAMS.—Nothing in this section shall apply to nego-
6 tiations between health care professionals and health
7 plans pertaining to benefits provided under any of
8 the following:

9 (A) The Medicare Program under title
10 XVIII of the Social Security Act (42 U.S.C.
11 1395 et seq.).

12 (B) The Medicaid program under title XIX
13 of the Social Security Act (42 U.S.C. 1396 et
14 seq.).

15 (C) The SCHIP program under title XXI
16 of the Social Security Act (42 U.S.C. 1397aa et
17 seq.).

18 (D) Chapter 55 of title 10, United States
19 Code (relating to medical and dental care for
20 members of the uniformed services).

21 (E) Chapter 17 of title 38, United States
22 Code (relating to Veterans' medical care).

23 (F) Chapter 89 of title 5, United States
24 Code (relating to the Federal employees' health
25 benefits program).

1 (G) The Indian Health Care Improvement
2 Act (25 U.S.C. 1601 et seq.).

3 (b) DEFINITIONS.—In this section, the following defi-
4 nitions shall apply:

5 (1) ANTITRUST LAWS.—The term “antitrust
6 laws”—

7 (A) has the meaning given it in subsection
8 (a) of the first section of the Clayton Act (15
9 U.S.C. 12(a)), except that such term includes
10 section 5 of the Federal Trade Commission Act
11 (15 U.S.C. 45) to the extent such section ap-
12 plies to unfair methods of competition; and

13 (B) includes any State law similar to the
14 laws referred to in subparagraph (A).

15 (2) GROUP HEALTH PLAN.—The term “group
16 health plan” means an employee welfare benefit plan
17 to the extent that the plan provides medical care (in-
18 cluding items and services paid for as medical care)
19 to employees or their dependents (as defined under
20 the terms of the plan) directly or through insurance,
21 reimbursement, or otherwise.

22 (3) GROUP HEALTH PLAN, HEALTH INSURANCE
23 ISSUER.—The terms “group health plan” and
24 “health insurance issuer” include a third-party ad-

1 administrator or other person acting for or on behalf
2 of such plan or issuer.

3 (4) HEALTH CARE SERVICES.—The term
4 “health care services” means any services for which
5 payment may be made under a health plan, includ-
6 ing services related to the delivery or administration
7 of such services.

8 (5) HEALTH CARE PROFESSIONAL.—The term
9 “health care professional” means any individual or
10 entity that provides health care items or services,
11 treatment, assistance with activities of daily living,
12 or medications to patients and who, to the extent re-
13 quired by State or Federal law, possesses specialized
14 training that confers expertise in the provision of
15 such items or services, treatment, assistance, or
16 medications.

17 (6) HEALTH INSURANCE COVERAGE.—The term
18 “health insurance coverage” means benefits con-
19 sisting of medical care (provided directly, through
20 insurance or reimbursement, or otherwise and in-
21 cluding items and services paid for as medical care)
22 under any hospital or medical service policy or cer-
23 tificate, hospital or medical service plan contract, or
24 health maintenance organization contract offered by
25 a health insurance issuer.

1 (7) HEALTH INSURANCE ISSUER.—The term
2 “health insurance issuer” means an insurance com-
3 pany, insurance service, or insurance organization
4 (including a health maintenance organization) that
5 is licensed to engage in the business of insurance in
6 a State and that is subject to State law regulating
7 insurance. Such term does not include a group
8 health plan.

9 (8) HEALTH MAINTENANCE ORGANIZATION.—
10 The term “health maintenance organization”
11 means—

12 (A) a federally qualified health mainte-
13 nance organization (as defined in section
14 1301(a) of the Public Health Service Act (42
15 U.S.C. 300e(a)));

16 (B) an organization recognized under State
17 law as a health maintenance organization; or

18 (C) a similar organization regulated under
19 State law for solvency in the same manner and
20 to the same extent as such a health mainte-
21 nance organization.

22 (9) HEALTH PLAN.—The term “health plan”
23 means a group health plan or a health insurance
24 issuer that is offering health insurance coverage.

1 (10) MEDICAL CARE.—The term “medical
2 care” means amounts paid for—

3 (A) the diagnosis, cure, mitigation, treat-
4 ment, or prevention of disease, or amounts paid
5 for the purpose of affecting any structure or
6 function of the body; and

7 (B) transportation primarily for and essen-
8 tial to receiving items and services referred to
9 in subparagraph (A).

10 (11) PERSON.—The term “person” includes a
11 State or unit of local government.

12 (12) STATE.—The term “State” includes the
13 several States, the District of Columbia, Puerto
14 Rico, the Virgin Islands of the United States, Guam,
15 American Samoa, and the Commonwealth of the
16 Northern Mariana Islands.

17 (c) EFFECTIVE DATE.—This section shall take effect
18 on on the date of the enactment of this Act and shall not
19 apply with respect to conduct occurring before such date.

20 **TITLE XIII—OFFSETS**

21 **Subtitle A—Discretionary**

22 **Spending Limits**

23 **SEC. 1301. DISCRETIONARY SPENDING LIMITS.**

24 Section 251(c) of the Balanced Budget and Emer-
25 gency Deficit Control Act of 1985 (2 U.S.C. 901(c)), as

1 amended by section 101 of the Budget Control Act of
2 2011, is amended to read as follows:

3 “(c) DISCRETIONARY SPENDING LIMIT.—As used in
4 this part, the term ‘discretionary spending limit’ means—

5 “(1) with respect to fiscal year 2012—

6 “(A) for the security category,
7 \$684,000,000,000 in new budget authority; and

8 “(B) for the nonsecurity category,
9 \$359,000,000,000 in new budget authority;

10 “(2) with respect to fiscal year 2013—

11 “(A) for the security category,
12 \$698,000,000,000 in new budget authority; and

13 “(B) for the nonsecurity category,
14 \$329,000,000,000 in new budget authority;

15 “(3) with respect to fiscal year 2014, for the
16 discretionary category, \$1,038,537,000,000 in new
17 budget authority;

18 “(4) with respect to fiscal year 2015, for the
19 discretionary category, \$1,046,680,000,000 in new
20 budget authority;

21 “(5) with respect to fiscal year 2016, for the
22 discretionary category, \$1,055,779,000,000 in new
23 budget authority;

1 “(6) with respect to fiscal year 2017, for the
2 discretionary category, \$1,067,794,000,000 in new
3 budget authority;

4 “(7) with respect to fiscal year 2018, for the
5 discretionary category, \$1,085,259,000,000 in new
6 budget authority;

7 “(8) with respect to fiscal year 2019, for the
8 discretionary category, \$1,103,802,000,000 in new
9 budget authority;

10 “(9) with respect to fiscal year 2020, for the
11 discretionary category, \$1,122,611,000,000 in new
12 budget authority; and

13 “(10) with respect to fiscal year 2021, for the
14 discretionary category, \$1,141,640,000,000 in new
15 budget authority;

16 as adjusted in strict conformance with subsection (b).”.

17 **Subtitle B—Savings From Health**
18 **Care Efficiencies**

19 **SEC. 1311. MEDICARE DSH REPORT AND PAYMENT ADJUST-**
20 **MENTS IN RESPONSE TO COVERAGE EXPAN-**
21 **SION.**

22 (a) DSH REPORT.—

23 (1) IN GENERAL.—Not later than January 1,
24 2016, the Secretary of Health and Human Services
25 shall submit to Congress a report on Medicare DSH

1 taking into account the impact of the health care re-
2 forms carried out under this Act in reducing the
3 number of uninsured individuals. The report shall
4 include recommendations relating to the following:

5 (A) The appropriate amount, targeting,
6 and distribution of Medicare DSH to com-
7 pensate for higher Medicare costs associated
8 with serving low-income beneficiaries (taking
9 into account variations in the empirical jus-
10 tification for Medicare DSH attributable to hos-
11 pital characteristics, including bed size), con-
12 sistent with the original intent of Medicare
13 DSH.

14 (B) The appropriate amount, targeting,
15 and distribution of Medicare DSH to hospitals
16 given their continued uncompensated care costs,
17 to the extent such costs remain.

18 (2) COORDINATION WITH MEDICAID DSH RE-
19 PORT.—The Secretary shall coordinate the report
20 under this subsection with the report on Medicaid
21 DSH under section 1322(a).

22 (b) PAYMENT ADJUSTMENTS IN RESPONSE TO COV-
23 ERAGE EXPANSION.—

24 (1) IN GENERAL.—If there is a significant de-
25 crease in the national rate of uninsurance as a result

1 of this Act (as determined under paragraph (2)(A)),
2 then the Secretary of Health and Human Services
3 shall, beginning in fiscal year 2017, implement the
4 following adjustments to Medicare DSH:

5 (A) In lieu of the amount of Medicare
6 DSH payment that would otherwise be made
7 under section 1886(d)(5)(F) of the Social Secu-
8 rity Act, the amount of Medicare DSH payment
9 shall be an amount based on the recommenda-
10 tions of the report under subsection (a)(1)(A)
11 and shall take into account variations in the
12 empirical justification for Medicare DSH attrib-
13 utable to hospital characteristics, including bed
14 size.

15 (B) Subject to paragraph (3), make an ad-
16 ditional payment to a hospital by an amount
17 that is estimated based on the amount of un-
18 compensated care provided by the hospital
19 based on criteria for uncompensated care as de-
20 termined by the Secretary, which shall exclude
21 bad debt.

22 (2) SIGNIFICANT DECREASE IN NATIONAL RATE
23 OF UNINSURANCE AS A RESULT OF THIS ACT.—For
24 purposes of this subsection—

1 (A) IN GENERAL.—There is a “significant
2 decrease in the national rate of uninsurance as
3 a result of this Act” if there is a decrease in
4 the national rate of uninsurance (as defined in
5 subparagraph (B)) from 2012 to 2014 that ex-
6 ceeds 8 percentage points.

7 (B) NATIONAL RATE OF UNINSURANCE
8 DEFINED.—The term “national rate of
9 uninsurance” means, for a year, such rate for
10 the under-65 population for the year as deter-
11 mined and published by the Bureau of the Cen-
12 sus in its Current Population Survey in or
13 about September of the succeeding year.

14 (3) UNCOMPENSATED CARE INCREASE.—

15 (A) COMPUTATION OF DSH SAVINGS.—For
16 each fiscal year (beginning with fiscal year
17 2015), the Secretary shall estimate the aggre-
18 gate reduction in Medicare DSH that will result
19 from the adjustment under paragraph (1)(A).

20 (B) STRUCTURE OF PAYMENT IN-
21 CREASE.—The Secretary shall compute the in-
22 crease in Medicare DSH under paragraph
23 (1)(B) for a fiscal year in accordance with a
24 formula established by the Secretary that pro-
25 vides that—

1 (i) the aggregate amount of such in-
2 crease for the fiscal year does not exceed
3 50 percent of the aggregate reduction in
4 Medicare DSH estimated by the Secretary
5 for such fiscal year; and

6 (ii) hospitals with higher levels of un-
7 compensated care receive a greater in-
8 crease.

9 (c) **MEDICARE DSH.**—In this section, the term
10 “Medicare DSH” means adjustments in payments under
11 section 1886(d)(5)(F) of the Social Security Act (42
12 U.S.C. 1395ww(d)(5)(F)) for inpatient hospital services
13 furnished by disproportionate share hospitals.

14 **SEC. 1312. REDUCTION IN MEDICAID DSH.**

15 (a) **REPORT.**—

16 (1) **IN GENERAL.**—Not later than January 1,
17 2016, the Secretary of Health and Human Services
18 (in this title referred to as the “Secretary”) shall
19 submit to Congress a report concerning the extent to
20 which, based upon the impact of the health care re-
21 forms carried out under this Act in reducing the
22 number of uninsured individuals, there is a contin-
23 ued role for Medicaid DSH. In preparing the report,
24 the Secretary shall consult with community-based

1 health care networks serving low-income bene-
2 ficiaries.

3 (2) MATTERS TO BE INCLUDED.—The report
4 shall include the following:

5 (A) RECOMMENDATIONS.—Recommendations regarding—
6

7 (i) the appropriate targeting of Medicaid DSH within States; and
8

9 (ii) the distribution of Medicaid DSH
10 among the States.

11 (B) SPECIFICATION OF DSH HEALTH RE-
12 FORM METHODOLOGY.—The DSH Health Re-
13 form methodology described in paragraph (2) of
14 subsection (b) for purposes of implementing the
15 requirements of such subsection.

16 (3) COORDINATION WITH MEDICARE DSH RE-
17 PORT.—The Secretary shall coordinate the report
18 under this subsection with the report on Medicare
19 DSH under section 1321.

20 (4) MEDICAID DSH.—In this section, the term
21 “Medicaid DSH” means adjustments in payments
22 under section 1923 of the Social Security Act for in-
23 patient hospital services furnished by dispropor-
24 tionate share hospitals.

25 (b) MEDICAID DSH REDUCTIONS.—

1 (1) IN GENERAL.—If there is a significant de-
2 crease in the national rate of uninsurance as a result
3 of this Act (as determined under section
4 1321(a)(2)(A)), then the Secretary of Health and
5 Human Services shall reduce Medicaid DSH so as to
6 reduce total Federal payments to all States for such
7 purpose by \$1,500,000,000 in fiscal year 2017,
8 \$2,500,000,000 in fiscal year 2018, and
9 \$6,000,000,000 in fiscal year 2019.

10 (2) DSH HEALTH REFORM METHODOLOGY.—
11 The Secretary shall carry out paragraph (1) through
12 use of a DSH Health Reform methodology issued by
13 the Secretary that imposes the largest percentage re-
14 ductions on the States that—

15 (A) have the lowest percentages of unin-
16 sured individuals (determined on the basis of
17 audited hospital cost reports) during the most
18 recent year for which such data are available;

19 or

20 (B) do not target their DSH payments
21 on—

22 (i) hospitals with high volumes of
23 Medicaid inpatients (as defined in section
24 1923(b)(1)(A) of the Social Security Act
25 (42 U.S.C. 1396r-4(b)(1)(A))); and

1 (ii) hospitals that have high levels of
2 uncompensated care (excluding bad debt).

3 (3) DSH ALLOTMENT PUBLICATIONS.—

4 (A) IN GENERAL.—Not later than the pub-
5 lication deadline specified in subparagraph (B),
6 the Secretary shall publish in the Federal Reg-
7 ister a notice specifying the DSH allotment to
8 each State under 1923(f) of the Social Security
9 Act for the respective fiscal year specified in
10 such subparagraph, consistent with the applica-
11 tion of the DSH Health Reform methodology
12 described in paragraph (2).

13 (B) PUBLICATION DEADLINE.—The publi-
14 cation deadline specified in this subparagraph
15 is—

16 (i) January 1, 2016, with respect to
17 DSH allotments described in subparagraph
18 (A) for fiscal year 2017;

19 (ii) January 1, 2017, with respect to
20 DSH allotments described in subparagraph
21 (A) for fiscal year 2018; and

22 (iii) January 1, 2018, with respect to
23 DSH allotments described in subparagraph
24 (A) for fiscal year 2019.

25 (c) CONFORMING AMENDMENTS.—

1 (1) Section 1923(f) of the Social Security Act
2 (42 U.S.C. 1396r-4(f)) is amended—

3 (A) by redesignating paragraph (7) as
4 paragraph (8); and

5 (B) by inserting after paragraph (6) the
6 following new paragraph:

7 “(7) SPECIAL RULE FOR FISCAL YEARS 2017,
8 2018, AND 2019.—Notwithstanding paragraph (2), if
9 the Secretary makes a reduction under section
10 1322(b)(1) of the Empowering Patients First Act,
11 the total DSH allotments for all States for—

12 “(A) fiscal year 2017, shall be the total
13 DSH allotments that would otherwise be deter-
14 mined under this subsection for such fiscal year
15 decreased by \$1,500,000,000;

16 “(B) fiscal year 2018, shall be the total
17 DSH allotments that would otherwise be deter-
18 mined under this subsection for such fiscal year
19 decreased by \$2,500,000,000; and

20 “(C) fiscal year 2019, shall be the total
21 DSH allotments that would otherwise be deter-
22 mined under this subsection for such fiscal year
23 decreased by \$6,000,000,000.”.

24 (2) Section 1923(b)(4) of such Act (42 U.S.C.
25 1396r-4(b)(4)) is amended by adding before the pe-

1 riod the following: “or to affect the authority of the
2 Secretary to issue and implement the DSH Health
3 Reform methodology under section 1322(b)(2) of the
4 Empowering Patients First Act”.

5 (d) DISPROPORTIONATE SHARE HOSPITALS (DSH)
6 AND ESSENTIAL ACCESS HOSPITAL (EAH) NON-DIS-
7 CRIMINATION.—

8 (1) IN GENERAL.—Section 1923(d) of the So-
9 cial Security Act (42 U.S.C. 1396r–4) is amended
10 by adding at the end the following new paragraph:

11 “(4) No hospital may be defined or deemed as
12 a disproportionate share hospital, or as an essential
13 access hospital (for purposes of subsection
14 (f)(6)(A)(iv)), under a State plan under this title or
15 subsection (b) of this section (including any waiver
16 under section 1115) unless the hospital—

17 “(A) provides services to beneficiaries
18 under this title without discrimination on the
19 ground of race, color, national origin, creed,
20 source of payment, status as a beneficiary
21 under this title, or any other ground unrelated
22 to such beneficiary’s need for the services or the
23 availability of the needed services in the hos-
24 pital; and

1 “(B) makes arrangements for, and accepts,
2 reimbursement under this title for services pro-
3 vided to eligible beneficiaries under this title.”.

4 (2) EFFECTIVE DATE.—The amendment made
5 by subsection (a) shall be apply to expenditures
6 made on or after July 1, 2012.

7 **Subtitle C—Fraud, Waste, and** 8 **Abuse**

9 **SEC. 1321. PROVIDE ADEQUATE FUNDING TO HHS OIG AND** 10 **HCFAC.**

11 (a) HCFAC FUNDING.—Section 1817(k)(3)(A) of
12 the Social Security Act (42 U.S.C. 1395i(k)(3)(A)) is
13 amended—

14 (1) in clause (i)—

15 (A) in subclause (IV), by striking at the
16 end “and”;

17 (B) in subclause (V)—

18 (i) by striking “for each fiscal year
19 after fiscal year 2010” and inserting “for
20 fiscal year 2011”; and

21 (ii) by striking the period at the end
22 and inserting “; and”; and

23 (C) by adding at the end the following new
24 subclause:

1 “(VI) for each fiscal year after
2 fiscal year 2011, \$300,000,000.”; and

3 (2) in clause (ii)—

4 (A) in subclause (IX), by striking at the
5 end “and”;

6 (B) in subclause (X)—

7 (i) by striking “for each fiscal year
8 after fiscal year 2010” and inserting “for
9 fiscal year 2011”; and

10 (ii) by striking the period at the end
11 and inserting “; and”; and

12 (C) by adding at the end the following new
13 subclause:

14 “(XI) for each fiscal year after
15 fiscal year 2011, not less than the
16 amount required under this clause for
17 fiscal year 2011, plus the amount by
18 which the amount made available
19 under clause (i)(VI) for fiscal year
20 2012 exceeds the amount made avail-
21 able under clause (i)(V) for fiscal year
22 2011.”.

23 (b) OIG FUNDING.—There are authorized to be ap-
24 propriated for each of fiscal years 2012 through 2021
25 \$100,000,000 for the Office of the Inspector General of

1 the Department of Health and Human Services for fraud
2 prevention activities under the Medicare and Medicaid
3 programs.

4 **SEC. 1322. IMPROVED ENFORCEMENT OF THE MEDICARE**
5 **SECONDARY PAYOR PROVISIONS.**

6 (a) IN GENERAL.—The Secretary, in coordination
7 with the Inspector General of the Department of Health
8 and Human Services, shall provide through the Coordina-
9 tion of Benefits Contractor for the identification of in-
10 stances where the Medicare program should be, but is not,
11 acting as a secondary payer to an individual's private
12 health benefits coverage under section 1862(b) of the So-
13 cial Security Act (42 U.S.C. 1395y(b)).

14 (b) UPDATING PROCEDURES.—The Secretary shall
15 update procedures for identifying and resolving credit bal-
16 ance situations which occur under the Medicare program
17 when payment under such title and from other health ben-
18 efit plans exceed the providers' charges or the allowed
19 amount.

20 (c) REPORT ON IMPROVED ENFORCEMENT.—Not
21 later than 1 year after the date of the enactment of this
22 Act, the Secretary shall submit a report to Congress on
23 progress made in improved enforcement of the Medicare
24 secondary payor provisions, including recoupment of credit
25 balances.

1 **SEC. 1323. STRENGTHEN MEDICARE PROVIDER ENROLL-**
2 **MENT STANDARDS AND SAFEGUARDS.**

3 (a) STRENGTHENING MEDICARE PROVIDER NUM-
4 BERS.—

5 (1) SCREENING NEW PROVIDERS.—As a condi-
6 tion of a provider of services or a supplier, including
7 durable medical equipment suppliers and home
8 health agencies, applying for the first time for a pro-
9 vider number under the Medicare program under
10 title XVIII of the Social Security Act and before
11 granting billing privileges under such title, the Sec-
12 retary of Health and Human Services (referred to in
13 this section as the “Secretary”) shall screen the pro-
14 vider or supplier for a criminal background or other
15 financial or operational irregularities through
16 fingerprinting, licensure checks, site-visits, and other
17 database checks.

18 (2) APPLICATION FEES.—The Secretary shall
19 impose an application charge on such a provider or
20 supplier in order to cover the Secretary’s costs in
21 performing the screening required under paragraph
22 (1).

23 (3) PROVISIONAL APPROVAL.—During an ini-
24 tial, provisional period (specified by the Secretary)
25 in which such a provider or supplier has been issued
26 such a number, the Secretary shall provide enhanced

1 oversight of the activities of such provider or sup-
2 plier under the Medicare program, such as through
3 prepayment review and payment limitations.

4 (4) PENALTIES FOR FALSE STATEMENTS.—In
5 the case of a provider or supplier that knowingly
6 makes a false statement in an application for such
7 a number, the Secretary may exclude the provider or
8 supplier from participation under the Medicare pro-
9 gram, or may impose a civil money penalty (in the
10 amount described in section 1128A(a)(4) of the So-
11 cial Security Act), in the same manner as the Sec-
12 retary may impose such an exclusion or penalty
13 under sections 1128 and 1128A, respectively, of
14 such Act in the case of knowing presentation of a
15 false claim described in section 1128A(a)(1)(A) of
16 such Act.

17 (5) DISCLOSURE REQUIREMENTS.—With re-
18 spect to approval of such an application, the Sec-
19 retary—

20 (A) shall require applicants to disclose pre-
21 vious affiliation with enrolled entities that have
22 uncollected debt related to the Medicare or
23 Medicaid programs;

24 (B) may deny approval if the Secretary de-
25 termines that these affiliations pose undue risk

1 to the Medicare or Medicaid program, subject
2 to an appeals process for the applicant as deter-
3 mined by the Secretary; and

4 (C) may implement enhanced safeguards
5 (such as surety bonds).

6 (b) MORATORIA.—The Secretary may impose mora-
7 toria on approval of provider and supplier numbers under
8 the Medicare program for new providers of services and
9 suppliers as determined necessary to prevent or combat
10 fraud a period of delay for any one applicant cannot ex-
11 ceed 30 days unless cause is shown by the Secretary.

12 (c) FUNDING.—There are authorized to be appro-
13 priated to carry out this section such sums as may be nec-
14 essary.

15 **SEC. 1324. TRACKING BANNED PROVIDERS ACROSS STATE**
16 **LINES.**

17 (a) GREATER COORDINATION.—The Secretary of
18 Health and Human Services (in this section referred to
19 as the “Secretary”) shall provide for increased coordina-
20 tion between the Administrator of the Centers for Medi-
21 care & Medicaid Services (in this section referred to as
22 “CMS”) and its regional offices to ensure that providers
23 of services and suppliers that have operated in one State
24 and are excluded from participation in the Medicare pro-

1 gram are unable to begin operation and participation in
2 the Medicare program in another State.

3 (b) IMPROVED INFORMATION SYSTEMS.—

4 (1) IN GENERAL.—The Secretary shall improve
5 information systems to allow greater integration be-
6 tween databases under the Medicare program so
7 that—

8 (A) Medicare administrative contractors,
9 fiscal intermediaries, and carriers have imme-
10 diate access to information identifying providers
11 and suppliers excluded from participation in the
12 Medicare and Medicaid program and other Fed-
13 eral health care programs; and

14 (B) such information can be shared across
15 Federal health care programs and agencies, in-
16 cluding between the Departments of Health and
17 Human Services, the Social Security Adminis-
18 tration, the Department of Veterans Affairs,
19 the Department of Defense, the Department of
20 Justice, and the Office of Personnel Manage-
21 ment.

22 (c) MEDICARE/MEDICAID “ONE PI” DATABASE.—
23 The Secretary shall implement a database that includes
24 claims and payment data for all components of the Medi-
25 care program and the Medicaid program.

1 (d) AUTHORIZING EXPANDED DATA MATCHING.—
2 Notwithstanding any provision of the Computer Matching
3 and Privacy Protection Act of 1988 to the contrary—

4 (1) the Secretary and the Inspector General in
5 the Department of Health and Human Services may
6 perform data matching of data from the Medicare
7 program with data from the Medicaid program; and

8 (2) the Commissioner of Social Security and the
9 Secretary may perform data matching of data of the
10 Social Security Administration with data from the
11 Medicare and Medicaid programs.

12 (e) CONSOLIDATION OF DATA BASES.—The Sec-
13 retary shall consolidate and expand into a centralized data
14 base for individuals and entities that have been excluded
15 from Federal health care programs the Healthcare Integ-
16 rity and Protection Data Bank, the National Practitioner
17 Data Bank, the List of Excluded Individuals/Entities, and
18 a national patient abuse/neglect registry.

19 (f) COMPREHENSIVE PROVIDER DATABASE.—

20 (1) ESTABLISHMENT.—The Secretary shall es-
21 tablish a comprehensive database that includes infor-
22 mation on providers of services, suppliers, and re-
23 lated entities participating in the Medicare program,
24 the Medicaid program, or both. Such database shall
25 include, information on ownership and business rela-

1 tionships, history of adverse actions, results of site
2 visits or other monitoring by any program.

3 (2) USE.—Prior to issuing a provider or sup-
4 plier number for an entity under the Medicare pro-
5 gram, the Secretary shall obtain information on the
6 entity from such database to assure the entity quali-
7 fies for the issuance of such a number.

8 (g) COMPREHENSIVE SANCTIONS DATABASE.—The
9 Secretary shall establish a comprehensive sanctions data-
10 base on sanctions imposed on providers of services, sup-
11 pliers, and related entities. Such database shall be over-
12 seen by the Inspector General of the Department of
13 Health and Human Services and shall be linked to related
14 databases maintained by State licensure boards and by
15 Federal or State law enforcement agencies.

16 (h) ACCESS TO CLAIMS AND PAYMENT DATA-
17 BASES.—The Secretary shall ensure that the Inspector
18 General of the Department of Health and Human Services
19 and Federal law enforcement agencies have direct access
20 to all claims and payment databases of the Secretary
21 under the Medicare or Medicaid programs.

22 (i) CIVIL MONEY PENALTIES FOR SUBMISSION OF
23 ERRONEOUS INFORMATION.—In the case of a provider of
24 services, supplier, or other entity that knowingly submits
25 erroneous information that serves as a basis for payment

1 of any entity under the Medicare or Medicaid program,
2 the Secretary may impose a civil money penalty of not to
3 exceed \$50,000 for each such erroneous submission. A
4 civil money penalty under this subsection shall be imposed
5 and collected in the same manner as a civil money penalty
6 under subsection (a) of section 1128A of the Social Secu-
7 rity Act is imposed and collected under that section.

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