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(Original Signature of Member)

111TH CONGRESS  
2D SESSION

**H. R.**

To repeal the Patient Protection and Affordable Care Act and to replace such Act with incentives to encourage health insurance coverage, and for other purposes.

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IN THE HOUSE OF REPRESENTATIVES

Mr. WILSON of South Carolina introduced the following bill; which was referred to the Committee on \_\_\_\_\_

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**A BILL**

To repeal the Patient Protection and Affordable Care Act and to replace such Act with 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 “Siding with America’s Patients 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.

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. Non-discrimination on abortion and respect for rights of conscience.
- 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. Require employers to disclose amounts paid for employer-provided health plan coverage.
- Sec. 111. 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.
- Sec. 404. Liability protections for health center volunteer practitioners.

Sec. 405. Liability protections for health center practitioners providing services in emergency areas.

TITLE V—MEDICAL LIABILITY AND UNCOMPENSATED CARE 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. Authorization of payment of future damages to claimants in health care lawsuits.
- Sec. 509. Definitions.
- Sec. 510. Effect on other laws.
- Sec. 511. State flexibility and protection of states' rights.
- Sec. 512. Applicability; effective date.
- Sec. 513. Sense of Congress.
- Sec. 514. State grants to create administrative health care tribunals.
- Sec. 515. Affirmative defense based on compliance with best practice guidelines.
- Sec. 516. 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.

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—PHYSICIAN PAYMENT REFORM

Sec. 1001. Sustainable growth rate reform.

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—OFFSETS

Subtitle A—Enforcing Discretionary Spending Limits

Sec. 1201. Enforcing discretionary spending limits.

Subtitle B—Repeal of Unused Stimulus Funds

Sec. 1211. Rescission and repeal in ARRA.

Subtitle C—Savings From Health Care Efficiencies

Sec. 1221. Medicare DSH report and payment adjustments in response to coverage expansion.

Sec. 1222. Reduction in Medicaid DSH.

Subtitle D—Fraud, Waste, and Abuse

Sec. 1231. Provide adequate funding to HHS OIG and HCFAC.

Sec. 1232. Improved enforcement of the Medicare secondary payor provisions.

Sec. 1233. Strengthen Medicare provider enrollment standards and safeguards.

Sec. 1234. Tracking banned providers across State lines.

Sec. 1235. Reinstate the Medicare trigger.

**1 SEC. 2. REPEAL OF PPACA.**

2       Effective as of the enactment of the Patient Protec-  
3 tion and Affordable Care Act, such Act is repealed, and  
4 the provisions of law amended or repealed by such Act  
5 are restored or revived as if such Act had not been en-  
6 acted.

**7 TITLE I—TAX INCENTIVES FOR**  
**8 MAINTAINING HEALTH IN-**  
**9 SURANCE COVERAGE**

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

12       (a) IN GENERAL.—Subpart C of part IV of sub-  
13 chapter A of chapter 1 of the Internal Revenue Code of  
14 1986 (relating to refundable credits) is amended by insert-  
15 ing after section 36A the following new section:

1 **“SEC. 36B. HEALTH INSURANCE COSTS OF LOW-INCOME IN-**  
2 **DIVIDUALS.**

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

9 “(b) LIMITATIONS.—

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

13 “(A) the sum of the monthly limitations  
14 for months during such taxable year that the  
15 taxpayer or the taxpayer’s qualifying family  
16 members is an eligible individual, and

17 “(B) the aggregate premiums paid by the  
18 taxpayer for the taxable year for coverage de-  
19 scribed in subsection (a).

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

23 “(A) \$2,000 for coverage of the taxpayer  
24 (\$4,000 in the case of a joint return for cov-  
25 erage of the taxpayer and the taxpayer’s  
26 spouse), and

1           “(B) \$500 for coverage of each dependent  
2 of the taxpayer.

3           “(3) CREDIT PERCENTAGE.—

4           “(A) IN GENERAL.—For purposes of this  
5 section, the term ‘credit percentage’ means 100  
6 percent reduced by 1 percentage point for each  
7 \$1,000 (or fraction thereof) by which the tax-  
8 payer’s adjusted gross income for the taxable  
9 year exceeds the threshold amount.

10           “(B) THRESHOLD AMOUNT.—For purposes  
11 of this paragraph, the term ‘threshold amount’  
12 means, with respect to any taxpayer for any  
13 taxable year, 200 percent of the Federal pov-  
14 erty guideline (as determined by the Secretary  
15 of Health and Human Service for the taxable  
16 year) applicable to the taxpayer.

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

21           “(5) INFLATION ADJUSTMENT.—In the case of  
22 any taxable year beginning in a calendar year after  
23 2009, each dollar amount contained in paragraph  
24 (2) shall be increased by an amount equal to—

25           “(A) such dollar amount, multiplied by

1           “(B) the cost-of-living adjustment deter-  
2           mined under section 1(f)(3) for the calendar  
3           year in which the taxable year begins, deter-  
4           mined by substituting ‘calendar year 2008’ for  
5           ‘calendar year 1992’ in subparagraph (B)  
6           thereof.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 “(g) SPECIAL RULES.—

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

5 “(A) the amount which would (but for this  
6 subsection) be allowed as a credit to the tax-  
7 payer under subsection (a) shall be reduced  
8 (but not below zero) by the aggregate amount  
9 paid on behalf of such taxpayer under section  
10 7529 for months beginning in such taxable  
11 year, and

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

15 “(i) the aggregate amount paid on be-  
16 half of such taxpayer under section 7529  
17 for months beginning in such taxable year,  
18 over

19 “(ii) the amount which would (but for  
20 this subsection) be allowed as a credit to  
21 the taxpayer under subsection (a).

22 “(2) COORDINATION WITH OTHER DEDUC-  
23 TIONS.—Amounts taken into account under sub-  
24 section (a) shall not be taken into account in deter-  
25 mining—

1           “(A) any deduction allowed under section  
2           162(1), 213, or 224, or

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

4           “(3) MEDICAL AND HEALTH SAVINGS AC-  
5           COUNTS.—Amounts distributed from an Archer  
6           MSA (as defined in section 220(d)) or from a health  
7           savings account (as defined in section 223(d)) shall  
8           not be taken into account under subsection (a).

9           “(4) DENIAL OF CREDIT TO DEPENDENTS AND  
10           NONPERMANENT RESIDENT ALIEN INDIVIDUALS.—  
11           No credit shall be allowed under this section to any  
12           individual who is—

13           “(A) not a citizen or lawful permanent  
14           resident of the United States for the calendar  
15           year in which the taxable year begins, or

16           “(B) a dependent with respect to another  
17           taxpayer for a taxable year beginning in the  
18           calendar year in which such individual’s taxable  
19           year begins.

20           “(5) INSURANCE WHICH COVERS OTHER INDI-  
21           VIDUALS.—For purposes of this section, rules simi-  
22           lar to the rules of section 213(d)(6) shall apply with  
23           respect to any contract for qualified health insurance  
24           under which amounts are payable for coverage of an

1 individual other than the taxpayer and qualifying  
2 family members.

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

5 “(A) PAYMENTS BY SECRETARY.—Pay-  
6 ments made by the Secretary on behalf of any  
7 individual under section 7529 (relating to ad-  
8 vance payment of credit for health insurance  
9 costs of low-income individuals) shall be treated  
10 as having been made by the taxpayer on the  
11 first day of the month for which such payment  
12 was made.

13 “(B) PAYMENTS BY TAXPAYER.—Pay-  
14 ments made by the taxpayer for eligible cov-  
15 erage months shall be treated as having been  
16 made by the taxpayer on the first day of the  
17 month for which such payment was made.

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

22 (b) CONFORMING AMENDMENTS.—

23 (1) Paragraph (2) of section 1324(b) of title  
24 31, United States Code, is amended by inserting  
25 “36B,” after “36A,”.

1           (2) The table of sections for subpart C of part  
2           IV of subchapter A of chapter 1 of the Internal Rev-  
3           enue Code of 1986 is amended by inserting after the  
4           item relating to section 36A the following new item:  
          “Sec. 36B. Health insurance costs of low-income individuals.”.

5           (c) EFFECTIVE DATE.—The amendments made by  
6           this section shall apply to taxable years beginning after  
7           December 31, 2009.

8           (d) SENSE OF CONGRESS.—It is the sense of Con-  
9           gress that the cost of the advanceable refundable credit  
10          under sections 36B and 7529 of the Internal Revenue  
11          Code of 1986, as added by this title, will be offset by sav-  
12          ings derived from the provisions of title XII.

13       **SEC. 102. ADVANCE PAYMENT OF CREDIT AS PREMIUM**  
14                       **PAYMENT FOR QUALIFIED HEALTH INSUR-**  
15                       **ANCE.**

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

19       **“SEC. 7529. ADVANCE PAYMENT OF CREDIT AS PREMIUM**  
20                       **PAYMENT FOR QUALIFIED HEALTH INSUR-**  
21                       **ANCE.**

22          “(a) GENERAL RULE.—Not later than January 1,  
23          2010, the Secretary shall establish a program for making  
24          payments to providers of qualified health insurance (as de-  
25          fined in section 36B(e)) on behalf of taxpayers eligible for

1 the credit under section 36B. Except as otherwise pro-  
2 vided by the Secretary, such payments shall be made on  
3 the basis of the adjusted gross income of the taxpayer for  
4 the preceding taxable year.

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

10 (b) DISCLOSURE OF RETURN INFORMATION FOR  
11 PURPOSES OF ADVANCE PAYMENT OF CREDIT AS PRE-  
12 MIUMS FOR QUALIFIED HEALTH INSURANCE.—

13 (1) IN GENERAL.—Subsection (1) of section  
14 6103 of such Code is amended by adding at the end  
15 the following new paragraph:

16 “(21) DISCLOSURE OF RETURN INFORMATION  
17 FOR PURPOSES OF ADVANCE PAYMENT OF CREDIT  
18 AS PREMIUMS FOR QUALIFIED HEALTH INSUR-  
19 ANCE.—The Secretary may, on behalf of taxpayers  
20 eligible for the credit under section 36B, disclose to  
21 a provider of qualified health insurance (as defined  
22 in section 36(e)), and persons acting on behalf of  
23 such provider, return information with respect to  
24 any such taxpayer only to the extent necessary (as  
25 prescribed by regulations issued by the Secretary) to

1 carry out the program established by section 7529  
2 (relating to advance payment of credit as premium  
3 payment for qualified health insurance).”.

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

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

11 (c) INFORMATION REPORTING.—

12 (1) IN GENERAL.—Subpart B of part III of  
13 subchapter A of chapter 61 of such Code (relating  
14 to information concerning transactions with other  
15 persons) is amended by adding at the end the fol-  
16 lowing new section:

17 **“SEC. 6050X. RETURNS RELATING TO CREDIT FOR HEALTH**  
18 **INSURANCE COSTS OF LOW-INCOME INDIVID-**  
19 **UALS.**

20 “(a) REQUIREMENT OF REPORTING.—Every person  
21 who is entitled to receive payments for any month of any  
22 calendar year under section 7529 (relating to advance pay-  
23 ment of credit as premium payment for qualified health  
24 insurance) with respect to any individual shall, at such  
25 time as the Secretary may prescribe, make the return de-

1 scribed in subsection (b) with respect to each such indi-  
2 vidual.

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

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

7 “(2) contains—

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

10 “(B) the number of months for which  
11 amounts were entitled to be received with re-  
12 spect to such individual under section 7529 (re-  
13 lating to advance payment of credit as premium  
14 payment for qualified health insurance),

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

17 “(D) such other information as the Sec-  
18 retary may prescribe.

19 “(c) STATEMENTS TO BE FURNISHED TO INDIVID-  
20 UALS WITH RESPECT TO WHOM INFORMATION IS RE-  
21 QUIRED.—Every person required to make a return under  
22 subsection (a) shall furnish to each individual whose name  
23 is required to be set forth in such return a written state-  
24 ment showing—

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

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

6 The written statement required under the preceding sen-  
7 tence shall be furnished on or before January 31 of the  
8 year following the calendar year for which the return  
9 under subsection (a) is required to be made.”.

10           (2) ASSESSABLE PENALTIES.—

11           (A) Subparagraph (B) of section  
12           6724(d)(1) of such Code (relating to defini-  
13           tions) is amended by striking “or” at the end  
14           of clause (xxii), by striking “and” at the end of  
15           clause (xxiii) and inserting “or”, and by insert-  
16           ing after clause (xxiii) the following new clause:

17                   “(xxiv) section 6050X (relating to re-  
18                   turns relating to credit for health insur-  
19                   ance costs of low-income individuals),  
20                   and”.

21           (B) Paragraph (2) of section 6724(d) of  
22           such Code is amended by striking “or” at the  
23           end of subparagraph (EE), by striking the pe-  
24           riod at the end of subparagraph (FF) and in-

1           serting “, or”, and by adding after subpara-  
2           graph (FF) the following new subparagraph:

3                   “(GG) section 6050X (relating to returns  
4           relating to credit for health insurance costs of  
5           low-income individuals).”.

6           (d) CLERICAL AMENDMENTS.—

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

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

10                   (2) The table of sections for subpart B of part  
11           III of subchapter A of chapter 61 of such Code is  
12           amended by adding at the end the following new  
13           item:

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

14           (e) EFFECTIVE DATE.—The amendments made by  
15           this section shall take effect on the date of the enactment  
16           of this Act.

17   **SEC. 103. ELECTION OF TAX CREDIT INSTEAD OF ALTER-**  
18                   **NATIVE GOVERNMENT OR GROUP PLAN BEN-**  
19                   **EFITS.**

20           (a) IN GENERAL.—Notwithstanding any other provi-  
21           sion of law, an individual who is otherwise eligible for ben-  
22           efits under a health program (as defined in subsection (e))  
23           may elect, in a form and manner specified by the Sec-

1   retary of Health and Human Services in consultation with  
2   the Secretary of the Treasury, to receive a tax credit de-  
3   scribed in section 36B of the Internal Revenue Code of  
4   1986 (which may be used for the purpose of health insur-  
5   ance coverage) in lieu of receiving any benefits under such  
6   program.

7       (b) EFFECTIVE DATE.—An election under subsection  
8   (a) may first be made for calendar year 2010 and any  
9   such election shall be effective for such period (not less  
10   than one calendar year) as the Secretary of Health and  
11   Human Services shall specify, in consultation with the  
12   Secretary of the Treasury.

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

16           (1) MEDICARE.—The medicare program under  
17           part A of title XVIII of the Social Security Act.

18           (2) MEDICAID.—The Medicaid program under  
19           title XIX of such Act (including such a program op-  
20           erating under a Statewide waiver under section 1115  
21           of such Act).

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

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



1 the taxpayer, his spouse, and dependents under qualified  
2 health insurance.

3 “(b) LIMITATION.—In the case of any taxpayer for  
4 any taxable year, the deduction under subsection (a) shall  
5 not exceed an amount that would cause the taxpayer’s  
6 Federal income tax liability to be reduced by more than  
7 the average value of the national health exclusion for em-  
8 ployer sponsored insurance as determined by calculating  
9 the value of the exclusion for each household followed by  
10 calculating the average of those values.

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

14 “(d) SPECIAL RULES.—

15 “(1) COORDINATION WITH MEDICAL DEDUC-  
16 TION, ETC.—Any amount paid by a taxpayer for in-  
17 surance to which subsection (a) applies shall not be  
18 taken into account in computing the amount allow-  
19 able to the taxpayer as a deduction under section  
20 162(l) or 213(a). Any amount taken into account in  
21 determining the credit allowed under section 35 or  
22 36B shall not be taken into account for purposes of  
23 this section.

24 “(2) DEDUCTION NOT ALLOWED FOR SELF-EM-  
25 PLOYMENT TAX PURPOSES.—The deduction allow-

1       able by reason of this section shall not be taken into  
2       account in determining an individual's net earnings  
3       from self-employment (within the meaning of section  
4       1402(a)) for purposes of chapter 2.”.

5       (b) DEDUCTION ALLOWED IN COMPUTING AD-  
6 JUSTED GROSS INCOME.—Subsection (a) of section 62 of  
7 such Code is amended by inserting before the last sentence  
8 the following new paragraph:

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

11       (c) CLERICAL AMENDMENT.—The table of sections  
12 for part VII of subchapter B of chapter 1 of such Code  
13 is amended by redesignating the item relating to section  
14 224 as an item relating to section 225 and inserting before  
15 such item the following new item:

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

16       (d) EFFECTIVE DATE.—The amendments made by  
17 this section shall apply to taxable years beginning after  
18 December 31, 2009.

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

20       No funds authorized under this Act (or any amend-  
21 ment made by this Act) may be used to pay for any abor-  
22 tion or to cover any part of the costs of any health plan  
23 that includes coverage of abortion, except in the case  
24 where a woman suffers from a physical disorder, physical  
25 injury, or physical illness that would, as certified by a phy-

1 sician, place the woman in danger of death unless an abor-  
2 tion is performed, including a life-endangering physical  
3 condition caused by or arising from the pregnancy itself,  
4 or unless the pregnancy is the result of an act of forcible  
5 rape or incest.

6 **SEC. 106. NON-DISCRIMINATION ON ABORTION AND RE-**  
7 **SPECT FOR RIGHTS OF CONSCIENCE.**

8 (a) NON-DISCRIMINATION.—A Federal agency or pro-  
9 gram, and any State or local government that receives  
10 Federal financial assistance, may not subject any indi-  
11 vidual or institutional health care entity to discrimination  
12 on the basis that the health care entity does not provide,  
13 pay for, provide coverage of, or refer for abortions.

14 (b) DEFINITION.—In this section, the term “health  
15 care entity” includes an individual physician or other  
16 health care professional, a hospital, a provider-sponsored  
17 organization, a health maintenance organization, a health  
18 insurance plan, or any other kind of health care facility,  
19 organization, or plan.

20 (c) ADMINISTRATION.—The Office for Civil Rights of  
21 the Department of Health and Human Services is des-  
22 ignated to receive complaints of discrimination based on  
23 this section, and coordinate the investigation of such com-  
24 plaints.

1 (d) CONSCIENTIOUS OBJECTION.—Nothing in this  
2 Act shall be construed as forbidding a health plan or  
3 health insurance issuer to accommodate the conscientious  
4 objection of a purchaser or an individual or institutional  
5 health care provider when a procedure is contrary to the  
6 religious beliefs or moral convictions of such purchaser or  
7 provider.

8 **SEC. 107. EQUAL EMPLOYER CONTRIBUTION RULE TO PRO-**  
9 **MOTE CHOICE.**

10 (a) EXCISE TAX FOR FAILURE TO PROVIDE CON-  
11 TRIBUTION ELECTION.—Section 5000 of the Internal  
12 Revenue Code of 1986 is amended by adding at the end  
13 the following new subsection:

14 “(e) HEALTH CARE CONTRIBUTION ELECTION.—

15 “(1) IN GENERAL.—Subsection (a) shall not  
16 apply in the case of a group health plan with respect  
17 to which the requirements of paragraphs (2) and (3)  
18 are met.

19 “(2) CONTRIBUTION ELECTION.—The require-  
20 ment of this paragraph is met with respect to a  
21 group health plan if any employee of an employer  
22 (who but for this paragraph would be covered by  
23 such plan) may elect to have the employer or em-  
24 ployee organization pay an amount which is not less  
25 than the contribution amount to any provider of in-

1 insurance (other than excepted benefits as defined in  
2 section 9832(c)(1)) which constitutes medical care of  
3 the individual or individual's spouse or dependents  
4 in lieu of such group health plan coverage otherwise  
5 provided or contributed to by the employer with re-  
6 spect to such employee.

7 “(3) PRE-EXISTING CONDITIONS.—

8 “(A) IN GENERAL.—The requirement of  
9 this paragraph is met with respect to health in-  
10 surance coverage provided to a participant or  
11 beneficiary by any health insurance issuer if,  
12 under such plan the requirements of section  
13 9801 are met with respect to the participant or  
14 beneficiary.

15 “(B) ENFORCEMENT WITH RESPECT TO  
16 INDIVIDUAL ELECTION.—For purposes of sub-  
17 paragraph (A), any health insurance coverage  
18 with respect to the participant or beneficiary  
19 shall be treated as health insurance coverage  
20 under a group health plan to which section  
21 9801 applies.

22 “(4) CONTRIBUTION AMOUNT.—For purposes  
23 of this section, the term ‘contribution amount’  
24 means, with respect to an individual under a group  
25 health plan, the portion of the applicable premium of

1       such individual under such plan (as determined  
2       under section 4980B(f)(4)) which is not paid by the  
3       individual. In the case that the employer offers more  
4       than one group health plan, the contribution amount  
5       shall be the average amount of the applicable pre-  
6       miums under such plans.

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

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

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

19               “(j) Notwithstanding the previous provisions of this  
20       section the Office of Personnel Management shall revise  
21       the amount of the Government contribution made under  
22       this section in a manner so that—

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

1           “(2) the aggregate amount of such contribu-  
2           tions is estimated to be equal to the aggregate  
3           amount of such contributions if this subsection did  
4           not apply.”.

5           (c) ERISA CONFORMING AMENDMENTS.—

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

12          “(e) HEALTH CARE CONTRIBUTION ELECTION.—

13                 “(1) IN GENERAL.—The requirements of this  
14                 part shall not apply in the case of health insurance  
15                 coverage (other than excepted benefits as defined in  
16                 section 9832(c)(1) of the Internal Revenue Code of  
17                 1986)—

18                         “(A) which is provided to a participant or  
19                         beneficiary by a health insurance issuer under  
20                         a group health plan, and

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

23                 “(2) CONTRIBUTION ELECTION.—The require-  
24                 ment of this paragraph is met with respect to health  
25                 insurance coverage provided to a participant or ben-

1       efficiary by any health insurance issuer under a  
2       group health plan if, under such plan—

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

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

14       “(3) PRE-EXISTING CONDITIONS.—

15              “(A) IN GENERAL.—The requirement of  
16              this paragraph is met with respect to health in-  
17              surance coverage provided to a participant or  
18              beneficiary by any health insurance issuer if,  
19              under such plan the requirements of section  
20              701 are met with respect to the participant or  
21              beneficiary.

22              “(B) ENFORCEMENT WITH RESPECT TO  
23              INDIVIDUAL ELECTION.—For purposes of sub-  
24              paragraph (A), any health insurance coverage  
25              with respect to the participant or beneficiary

1 shall be treated as health insurance coverage  
2 under a group health plan to which section 701  
3 applies.

4 “(4) CONTRIBUTION AMOUNT.—

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

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

1           (2) EXEMPTION FROM FIDUCIARY LIABILITY.—

2           Section 404 of such Act (29 U.S.C. 1104) is amend-  
3           ed by adding at the end the following new sub-  
4           section:

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

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

22          “(d) HEALTH CARE CONTRIBUTION ELECTION.—

23                  “(1) IN GENERAL.—The requirements of this  
24                  chapter shall not apply in the case of health insur-

1       ance coverage (other than excepted benefits as de-  
2       fined in section 9832(c)(1))—

3               “(A) which is provided to a participant or  
4       beneficiary by a health insurance issuer under  
5       a group health plan, and

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

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

13              “(A) the participant may elect such cov-  
14      erage for any period of coverage in lieu of  
15      health insurance coverage otherwise provided  
16      under such plan for such period, and

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

24              “(3) PRE-EXISTING CONDITIONS.—

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

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

15          “(4) CONTRIBUTION AMOUNT.—

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

1           tribution amount shall be the average amount  
2           of the applicable premiums under such plans.

3           “(B) APPLICABLE PREMIUM.—For pur-  
4           poses of subparagraph (A), the term ‘applicable  
5           premium’ means, with respect to any period of  
6           health insurance coverage of a participant or  
7           beneficiary under a group health plan, the cost  
8           to the plan for such period of such coverage for  
9           similarly situated beneficiaries (without regard  
10          to whether such cost is paid by the plan spon-  
11          sor or the participant or beneficiary).”.

12          (e) EXCEPTION FROM HIPAA REQUIREMENTS  
13 UNDER THE PHSA FOR BENEFITS PROVIDED UNDER  
14 HEALTH CARE CONTRIBUTION ELECTION.—Section 2721  
15 of the Public Health Service Act (42 U.S.C. 300gg–21)  
16 is amended—

17           (1) by redesignating subsection (e) as sub-  
18          section (f); and

19           (2) by inserting after subsection (d) the fol-  
20          lowing new subsection:

21          “(e) HEALTH CARE CONTRIBUTION ELECTION.—

22           “(1) IN GENERAL.—The requirements of this  
23          subparts 1 through 3 shall not apply in the case of  
24          health insurance coverage (other than excepted bene-

1 fits as defined in section 9832(c)(1) of the Internal  
2 Revenue Code of 1986)—

3 “(A) which is provided to a participant or  
4 beneficiary by a health insurance issuer under  
5 a group health plan, and

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

8 “(2) CONTRIBUTION ELECTION.—The require-  
9 ment of this paragraph is met with respect to health  
10 insurance coverage provided to a participant or ben-  
11 efiiciary by any health insurance issuer under a  
12 group health plan if, under such plan—

13 “(A) the participant may elect such cov-  
14 erage for any period of coverage in lieu of  
15 health insurance coverage otherwise provided  
16 under such plan for such period, and

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

24 “(3) PRE-EXISTING CONDITIONS.—

1           “(A) IN GENERAL.—The requirement of  
2           this paragraph is met with respect to health in-  
3           surance coverage provided to a participant or  
4           beneficiary by any health insurance issuer if,  
5           under such plan the requirements of section  
6           2701 are met with respect to the participant or  
7           beneficiary.

8           “(B) ENFORCEMENT WITH RESPECT TO  
9           INDIVIDUAL ELECTION.—For purposes of sub-  
10          paragraph (A), any health insurance coverage  
11          with respect to the participant or beneficiary  
12          shall be treated as health insurance coverage  
13          under a group health plan to which section  
14          2701 applies.

15          “(4) CONTRIBUTION AMOUNT.—

16          “(A) IN GENERAL.—For purposes of this  
17          section, the term ‘contribution amount’ means,  
18          with respect to any period of health insurance  
19          coverage offered to a participant or beneficiary,  
20          the portion of the applicable premium of such  
21          participant or beneficiary under such plan  
22          which is not paid by such participant or bene-  
23          ficiary. In the case that the employer offers  
24          more than one group health plan, the contribu-

1           tion amount shall be the average amount of the  
2           applicable premiums under such plans.

3           “(B) APPLICABLE PREMIUM.—For pur-  
4           poses of subparagraph (A), the term ‘applicable  
5           premium’ means, with respect to any period of  
6           health insurance coverage of a participant or  
7           beneficiary under a group health plan, the cost  
8           to the plan for such period of such coverage for  
9           similarly situated beneficiaries (without regard  
10          to whether such cost is paid by the plan spon-  
11          sor or the participant or beneficiary).”.

12 **SEC. 108. LIMITATIONS ON STATE RESTRICTIONS ON EM-**  
13 **EMPLOYER AUTO-ENROLLMENT.**

14          (a) IN GENERAL.—No State shall establish a law  
15          that prevents an employer from instituting auto-enroll-  
16          ment which meets the requirements of subsection (b) for  
17          coverage of a participant or beneficiary under a group  
18          health plan, or health insurance coverage offered in con-  
19          nection with such a plan, so long as the participant or  
20          beneficiary has the option of declining such coverage.

21          (b) AUTOMATIC ENROLLMENT FOR EMPLOYER  
22          SPONSORED HEALTH BENEFITS.—

23                  (1) IN GENERAL.—The requirement of this sub-  
24          section with respect to an employer and an employee  
25          is that the employer automatically enroll such em-

1        ployee into the employment-based health benefits  
2        plan for individual coverage under the plan option  
3        with the lowest applicable employee premium.

4            (2) OPT-OUT.—In no case may an employer  
5        automatically enroll an employee in a plan under  
6        paragraph (1) if such employee makes an affirmative  
7        election to opt-out of such plan or to elect coverage  
8        under an employment-based health benefits plan of-  
9        fered by such employer. An employer shall provide  
10       an employee with a 30-day period to make such an  
11       affirmative election before the employer may auto-  
12       matically enroll the employee in such a plan.

13            (3) NOTICE REQUIREMENTS.—

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

1 by the average employee to whom the automatic  
2 enrollment requirement applies.

3 (B) INCLUSION OF SPECIFIC INFORMA-  
4 TION.—The written notice under subparagraph  
5 (A) must explain an employee’s right to opt out  
6 of being automatically enrolled in a plan and in  
7 the case that more than one level of benefits or  
8 employee premium level is offered by the em-  
9 ployer involved, the notice must explain which  
10 level of benefits and employee premium level the  
11 employee will be automatically enrolled in the  
12 absence of an affirmative election by the em-  
13 ployee.

14 (c) CONSTRUCTION.—Nothing in this section shall be  
15 construed to supersede State law which establishes, imple-  
16 ments, or continues in effect any standard or requirement  
17 relating to employers in connection with payroll or the  
18 sponsoring of employer sponsored health insurance cov-  
19 erage except to the extent that such standard or require-  
20 ment prevents an employer from instituting the auto-en-  
21 rollment described in subsection (a).

1 **SEC. 109. CREDIT FOR SMALL EMPLOYERS ADOPTING**  
2 **AUTO-ENROLLMENT AND DEFINED CON-**  
3 **TRIBUTION OPTIONS.**

4 (a) IN GENERAL.—Subpart D of part IV of sub-  
5 chapter A of chapter 1 of the Internal Revenue Code of  
6 1986 (relating to business-related credits) is amended by  
7 adding at the end the following new section:

8 **“SEC. 45R. AUTO-ENROLLMENT AND DEFINED CONTRIBU-**  
9 **TION OPTION FOR HEALTH BENEFITS PLANS**  
10 **OF SMALL EMPLOYERS.**

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

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

20 “(1) \$1,500, over

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

24 “(c) QUALIFIED HEALTH BENEFITS EXPENSES.—  
25 For purposes of this section, the term ‘qualified health  
26 benefits auto-enrollment expenses’ means, with respect to

1 any taxable year, amounts paid or incurred by the tax-  
2 payer during such taxable year for—

3 “(1) establishing auto-enrollment which meets  
4 the requirements of section 107 of the Siding with  
5 America’s Patients Act for coverage of a participant  
6 or beneficiary under a group health plan, or health  
7 insurance coverage offered in connection with such a  
8 plan, and

9 “(2) implementing the employer contribution  
10 option for health insurance coverage pursuant to  
11 section 5000(e)(2).

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

19 “(e) NO DOUBLE BENEFIT.—No deduction or credit  
20 shall be allowed under any other provision of this chapter  
21 with respect to the amount of the credit determined under  
22 this section.

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

1 (b) CREDIT TO BE PART OF GENERAL BUSINESS  
2 CREDIT.—Subsection (b) of section 38 of such Code (re-  
3 lating to general business credit) is amended by striking  
4 “plus” at the end of paragraph (34), by striking the period  
5 at the end of paragraph (35) and inserting “, plus” , and  
6 by adding at the end the following new paragraph:

7 “(36) in the case of a small employer (as de-  
8 fined in section 45R(d)), the health benefits plan im-  
9 plementation credit determined under section  
10 45R(a).”.

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

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

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

18 **SEC. 110. REQUIRE EMPLOYERS TO DISCLOSE AMOUNTS**  
19 **PAID FOR EMPLOYER-PROVIDED HEALTH**  
20 **PLAN COVERAGE.**

21 (a) IN GENERAL.—Subsection (a) of section 6051 is  
22 amended by striking “and” at the end of paragraph (12),  
23 by striking the period at the end of paragraph (13) and

1 inserting “, and”, and by inserting after paragraph (13)  
2 the following new paragraph:

3 “(14) the total amount paid or incurred by the  
4 employer with respect to employer-provided coverage  
5 under an accident or health plan with respect to  
6 such employee.”.

7 (b) EFFECTIVE DATE.—The amendments made by  
8 this section shall apply to amounts paid or incurred in cal-  
9 endar years beginning after the date of the enactment of  
10 this Act.

11 **SEC. 111. HSA MODIFICATIONS AND CLARIFICATIONS.**

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

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

20 (b) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR  
21 VETERANS OR INDIAN HEALTH BENEFITS.—Section  
22 223(c)(1) of such Code (defining eligible individual) is  
23 amended by adding at the end the following new subpara-  
24 graph:

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

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

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

17           (d) EFFECTIVE DATE.—The amendment made by  
18 this section shall apply to taxable years beginning after  
19 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).

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 each fiscal year  
18     for block grants under this section. Such amount  
19     shall be divided among the States as determined by  
20     the Secretary.

21               (2) CONSTRUCTION.—Nothing in this section  
22     shall be construed as preventing a State from using  
23     funding under section 2745 of the Public Health  
24     Service Act for purposes of funding reinsurance or  
25     other risk mechanisms.

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

3 (1) QUALIFYING HIGH-RISK POOLS.—

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

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

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

21 (ii) offers multiple competing health  
22 plan options; and

23 (iii) covers only high risk populations.

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

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

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

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

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

23                  (1) Providing guaranteed availability of indi-  
24          vidual health insurance coverage to certain individ-

1 uals with prior group coverage under part B of title  
2 XXVII of the Public Health Service Act.

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

5 (3) An expansion or broadening of the pool of  
6 high risk individuals eligible for coverage.

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

11 The Secretary may request such Association to update  
12 such Model Health Plan as needed by 2011.

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

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

23 (g) QUALIFYING HIGH-RISK POOL.—For purposes of  
24 this section, the term “qualifying high-risk pool” means  
25 any qualified high risk pool (as defined in subsection

1 (g)(1)(A) of section 2745) of the Public Health Service  
2 Act) that meets the conditions to receive a grant under  
3 section (b)(1) of such section.

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

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

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

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

20 (j) STATE DEFINED.—For purposes of this section,  
21 the term “State” includes the District of Columbia, Puer-  
22 to Rico, the Virgin Islands, Guam, American Samoa, and  
23 the Northern Mariana Islands.

24 (k) EXTENDING FUNDING.—Section 2745(d)(2) of  
25 the Public Health Service Act (42 U.S.C. 300gg–45(d)(2))

1 is amended by striking “2010” and inserting “2012” each  
2 place it appears.

3 **Subtitle C—Health Care Access and**  
4 **Availability**

5 **SEC. 221. EXPANSION OF ACCESS AND CHOICE THROUGH**  
6 **INDIVIDUAL MEMBERSHIP ASSOCIATIONS**  
7 **(IMAS).**

8 The Public Health Service Act is amended by adding  
9 at the end the following new title:

10 **“TITLE XXXI—INDIVIDUAL**  
11 **MEMBERSHIP ASSOCIATIONS**

12 **“SEC. 3101. DEFINITION OF INDIVIDUAL MEMBERSHIP AS-**  
13 **SOCIATION (IMA).**

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

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

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

22 “(A) DIFFERENT GROUPS.—The IMA, in  
23 conjunction with those health insurance issuers  
24 that offer health benefits coverage through the  
25 IMA, makes available health benefits coverage

1 in the manner described in subsection (b) to all  
2 members of the IMA and the dependents of  
3 such members in the manner described in sub-  
4 section (c)(2) at rates that are established by  
5 the health insurance issuer on a policy or prod-  
6 uct specific basis and that may vary only as  
7 permissible under State law.

8 “(B) NONDISCRIMINATION IN COVERAGE  
9 OFFERED.—

10 “(i) IN GENERAL.—Subject to clause  
11 (ii), the IMA may not offer health benefits  
12 coverage to a member of an IMA unless  
13 the same coverage is offered to all such  
14 members of the IMA.

15 “(ii) CONSTRUCTION.—Nothing in  
16 this title shall be construed as requiring or  
17 permitting a health insurance issuer to  
18 provide coverage outside the service area of  
19 the issuer, as approved under State law, or  
20 requiring a health insurance issuer from  
21 excluding or limiting the coverage on any  
22 individual, subject to the requirement of  
23 section 2741.

24 “(C) NO FINANCIAL UNDERWRITING.—The  
25 IMA provides health benefits coverage only

1 through contracts with health insurance issuers  
2 and does not assume insurance risk with re-  
3 spect to such coverage.

4 “(3) GEOGRAPHIC AREAS.—Nothing in this title  
5 shall be construed as preventing the establishment  
6 and operation of more than one IMA in a geographic  
7 area or as limiting the number of IMAs that may  
8 operate in any area.

9 “(4) PROVISION OF ADMINISTRATIVE SERVICES  
10 TO PURCHASERS.—

11 “(A) IN GENERAL.—The IMA may provide  
12 administrative services for members. Such serv-  
13 ices may include accounting, billing, and enroll-  
14 ment information.

15 “(B) CONSTRUCTION.—Nothing in this  
16 subsection shall be construed as preventing an  
17 IMA from serving as an administrative service  
18 organization to any entity.

19 “(5) FILING INFORMATION.—The IMA files  
20 with the Secretary information that demonstrates  
21 the IMA’s compliance with the applicable require-  
22 ments of this title.

23 “(b) HEALTH BENEFITS COVERAGE REQUIRE-  
24 MENTS.—

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

4                   “(A) be underwritten by a health insurance  
5           issuer that—

6                           “(i) is licensed (or otherwise regu-  
7                           lated) under State law,

8                           “(ii) meets all applicable State stand-  
9                           ards relating to consumer protection, sub-  
10                          ject to section 3002(b), and

11                          “(B) subject to paragraph (2), be approved  
12                          or otherwise permitted to be offered under  
13                          State law.

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

19                          “(A) Coverage through a health mainte-  
20                          nance organization.

21                          “(B) Coverage in connection with a pre-  
22                          ferred provider organization.

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

1           “(D) Indemnity coverage through an insur-  
2           ance company.

3           “(E) Coverage offered in connection with a  
4           contribution into a medical savings account or  
5           flexible spending account.

6           “(F) Coverage that includes a point-of-  
7           service option.

8           “(G) Any combination of such types of  
9           coverage.

10          “(3) WELLNESS BONUSES FOR HEALTH PRO-  
11          MOTION.—Nothing in this title shall be construed as  
12          precluding a health insurance issuer offering health  
13          benefits coverage through an IMA from establishing  
14          premium discounts or rebates for members or from  
15          modifying otherwise applicable copayments or  
16          deductibles in return for adherence to programs of  
17          health promotion and disease prevention so long as  
18          such programs are agreed to in advance by the IMA  
19          and comply with all other provisions of this title and  
20          do not discriminate among similarly situated mem-  
21          bers.

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

23                 “(1) MEMBERS.—

24                 “(A) IN GENERAL.—Under rules estab-  
25                 lished to carry out this title, with respect to an

1 individual who is a member of an IMA, the in-  
2 dividual may enroll for health benefits coverage  
3 (including coverage for dependents of such indi-  
4 vidual) offered by a health insurance issuer  
5 through the IMA.

6 “(B) RULES FOR ENROLLMENT.—Nothing  
7 in this paragraph shall preclude an IMA from  
8 establishing rules of enrollment and reenroll-  
9 ment of members. Such rules shall be applied  
10 consistently to all members within the IMA and  
11 shall not be based in any manner on health sta-  
12 tus-related factors.

13 “(2) HEALTH INSURANCE ISSUERS.—The con-  
14 tract between an IMA and a health insurance issuer  
15 shall provide, with respect to a member enrolled with  
16 health benefits coverage offered by the issuer  
17 through the IMA, for the payment of the premiums  
18 collected by the issuer.

19 **“SEC. 3102. APPLICATION OF CERTAIN LAWS AND REQUIRE-**  
20 **MENTS.**

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

24 “(1) Benefit requirements for health benefits  
25 coverage offered through an IMA, including (but not

1 limited to) requirements relating to coverage of spe-  
2 cific providers, specific services or conditions, or the  
3 amount, duration, or scope of benefits, but not in-  
4 cluding requirements to the extent required to imple-  
5 ment title XXVII or other Federal law and to the  
6 extent the requirement prohibits an exclusion of a  
7 specific disease from such coverage.

8 “(2) Any other requirements (including limita-  
9 tions on compensation arrangements) that, directly  
10 or indirectly, preclude (or have the effect of pre-  
11 cluding) the offering of such coverage through an  
12 IMA, if the IMA meets the requirements of this  
13 title.

14 Any State law or regulation relating to the composition  
15 or organization of an IMA is preempted to the extent the  
16 law or regulation is inconsistent with the provisions of this  
17 title.

18 **“SEC. 3103. ADMINISTRATION.**

19 “(a) IN GENERAL.—The Secretary shall administer  
20 this title and is authorized to issue such regulations as  
21 may be required to carry out this title. Such regulations  
22 shall be subject to Congressional review under the provi-  
23 sions of chapter 8 of title 5, United States Code. The Sec-  
24 retary shall incorporate the process of ‘deemed file and  
25 use’ with respect to the information filed under section

1 3001(a)(5)(A) and shall determine whether information  
2 filed by an IMA demonstrates compliance with the applica-  
3 ble requirements of this title. The Secretary shall exercise  
4 authority under this title in a manner that fosters and  
5 promotes the development of IMAs in order to improve  
6 access to health care coverage and services.

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

15 **“SEC. 3104. DEFINITIONS.**

16 “For purposes of this title:

17 “(1) ASSOCIATION.—The term ‘association’  
18 means, with respect to health insurance coverage of-  
19 fered in a State, an association which—

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

22 “(B) has been formed and maintained in  
23 good faith for purposes other than obtaining in-  
24 surance;

1           “(C) does not condition membership in the  
2           association on any health status-related factor  
3           relating to an individual (including an employee  
4           of an employer or a dependent of an employee);  
5           and

6           “(D) does not make health insurance cov-  
7           erage offered through the association available  
8           other than in connection with a member of the  
9           association.

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

18          “(3) HEALTH BENEFITS COVERAGE.—The term  
19          ‘health benefits coverage’ has the meaning given the  
20          term health insurance coverage in section  
21          2791(b)(1).

22          “(4) HEALTH INSURANCE ISSUER.—The term  
23          ‘health insurance issuer’ has the meaning given such  
24          term in section 2791(b)(2).

1           “(5) HEALTH STATUS-RELATED FACTOR.—The  
2 term ‘health status-related factor’ has the meaning  
3 given such term in section 2791(d)(9).

4           “(6) IMA; INDIVIDUAL MEMBERSHIP ASSOCIA-  
5 TION.—The terms ‘IMA’ and ‘individual membership  
6 association’ are defined in section 3101(a).

7           “(7) MEMBER.—The term ‘member’ means,  
8 with respect to an IMA, an individual who is a mem-  
9 ber of the association to which the IMA is offering  
10 coverage.”.

## 11   **Subtitle D—Small Business Health** 12                                   **Fairness**

### 13   **SEC. 231. SHORT TITLE.**

14           This subtitle may be cited as the “Small Business  
15 Health Fairness Act of 2009”.

### 16   **SEC. 232. RULES GOVERNING ASSOCIATION HEALTH** 17                                   **PLANS.**

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

## 21   **“PART 8—RULES GOVERNING ASSOCIATION** 22                                   **HEALTH PLANS**

### 23   **“SEC. 801. ASSOCIATION HEALTH PLANS.**

24           “(a) IN GENERAL.—For purposes of this part, the  
25 term ‘association health plan’ means a group health plan

1 whose sponsor is (or is deemed under this part to be) de-  
2 scribed in subsection (b).

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

5 “(1) is organized and maintained in good faith,  
6 with a constitution and bylaws specifically stating its  
7 purpose and providing for periodic meetings on at  
8 least an annual basis, as a bona fide trade associa-  
9 tion, a bona fide industry association (including a  
10 rural electric cooperative association or a rural tele-  
11 phone cooperative association), a bona fide profes-  
12 sional association, or a bona fide chamber of com-  
13 merce (or similar bona fide business association, in-  
14 cluding a corporation or similar organization that  
15 operates on a cooperative basis (within the meaning  
16 of section 1381 of the Internal Revenue Code of  
17 1986)), for substantial purposes other than that of  
18 obtaining or providing medical care;

19 “(2) is established as a permanent entity which  
20 receives the active support of its members and re-  
21 quires for membership payment on a periodic basis  
22 of dues or payments necessary to maintain eligibility  
23 for membership in the sponsor; and

24 “(3) does not condition membership, such dues  
25 or payments, or coverage under the plan on the

1 basis of health status-related factors with respect to  
2 the employees of its members (or affiliated mem-  
3 bers), or the dependents of such employees, and does  
4 not condition such dues or payments on the basis of  
5 group health plan participation.

6 Any sponsor consisting of an association of entities which  
7 meet the requirements of paragraphs (1), (2), and (3)  
8 shall be deemed to be a sponsor described in this sub-  
9 section.

10 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**  
11 **PLANS.**

12 “(a) IN GENERAL.—The applicable authority shall  
13 prescribe by regulation a procedure under which, subject  
14 to subsection (b), the applicable authority shall certify as-  
15 sociation health plans which apply for certification as  
16 meeting the requirements of this part.

17 “(b) STANDARDS.—Under the procedure prescribed  
18 pursuant to subsection (a), in the case of an association  
19 health plan that provides at least one benefit option which  
20 does not consist of health insurance coverage, the applica-  
21 ble authority shall certify such plan as meeting the re-  
22 quirements of this part only if the applicable authority is  
23 satisfied that the applicable requirements of this part are  
24 met (or, upon the date on which the plan is to commence  
25 operations, will be met) with respect to the plan.

1           “(c) REQUIREMENTS APPLICABLE TO CERTIFIED  
2 PLANS.—An association health plan with respect to which  
3 certification under this part is in effect shall meet the ap-  
4 plicable requirements of this part, effective on the date  
5 of certification (or, if later, on the date on which the plan  
6 is to commence operations).

7           “(d) REQUIREMENTS FOR CONTINUED CERTIFI-  
8 CATION.—The applicable authority may provide by regula-  
9 tion for continued certification of association health plans  
10 under this part.

11           “(e) CLASS CERTIFICATION FOR FULLY INSURED  
12 PLANS.—The applicable authority shall establish a class  
13 certification procedure for association health plans under  
14 which all benefits consist of health insurance coverage.  
15 Under such procedure, the applicable authority shall pro-  
16 vide for the granting of certification under this part to  
17 the plans in each class of such association health plans  
18 upon appropriate filing under such procedure in connec-  
19 tion with plans in such class and payment of the pre-  
20 scribed fee under section 807(a).

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

1           “(1) a plan which offered such coverage on the  
2           date of the enactment of the Small Business Health  
3           Fairness Act of 2009,

4           “(2) a plan under which the sponsor does not  
5           restrict membership to one or more trades and busi-  
6           nesses or industries and whose eligible participating  
7           employers represent a broad cross-section of trades  
8           and businesses or industries, or

9           “(3) a plan whose eligible participating employ-  
10          ers represent one or more trades or businesses, or  
11          one or more industries, consisting of any of the fol-  
12          lowing: agriculture; equipment and automobile deal-  
13          erships; barbering and cosmetology; certified public  
14          accounting practices; child care; construction; dance,  
15          theatrical and orchestra productions; disinfecting  
16          and pest control; financial services; fishing; food  
17          service establishments; hospitals; labor organiza-  
18          tions; logging; manufacturing (metals); mining; med-  
19          ical and dental practices; medical laboratories; pro-  
20          fessional consulting services; sanitary services; trans-  
21          portation (local and freight); warehousing; whole-  
22          saling/distributing; or any other trade or business or  
23          industry which has been indicated as having average  
24          or above-average risk or health claims experience by  
25          reason of State rate filings, denials of coverage, pro-

1 posed premium rate levels, or other means dem-  
2 onstrated by such plan in accordance with regula-  
3 tions.

4 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**  
5 **BOARDS OF TRUSTEES.**

6 “(a) SPONSOR.—The requirements of this subsection  
7 are met with respect to an association health plan if the  
8 sponsor has met (or is deemed under this part to have  
9 met) the requirements of section 801(b) for a continuous  
10 period of not less than 3 years ending with the date of  
11 the application for certification under this part.

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

15 “(1) FISCAL CONTROL.—The plan is operated,  
16 pursuant to a trust agreement, by a board of trust-  
17 ees which has complete fiscal control over the plan  
18 and which is responsible for all operations of the  
19 plan.

20 “(2) RULES OF OPERATION AND FINANCIAL  
21 CONTROLS.—The board of trustees has in effect  
22 rules of operation and financial controls, based on a  
23 3-year plan of operation, adequate to carry out the  
24 terms of the plan and to meet all requirements of  
25 this title applicable to the plan.

1           “(3) RULES GOVERNING RELATIONSHIP TO  
2 PARTICIPATING EMPLOYERS AND TO CONTRAC-  
3 TORS.—

4           “(A) BOARD MEMBERSHIP.—

5           “(i) IN GENERAL.—Except as pro-  
6 vided in clauses (ii) and (iii), the members  
7 of the board of trustees are individuals se-  
8 lected from individuals who are the owners,  
9 officers, directors, or employees of the par-  
10 ticipating employers or who are partners in  
11 the participating employers and actively  
12 participate in the business.

13           “(ii) LIMITATION.—

14           “(I) GENERAL RULE.—Except as  
15 provided in subclauses (II) and (III),  
16 no such member is an owner, officer,  
17 director, or employee of, or partner in,  
18 a contract administrator or other  
19 service provider to the plan.

20           “(II) LIMITED EXCEPTION FOR  
21 PROVIDERS OF SERVICES SOLELY ON  
22 BEHALF OF THE SPONSOR.—Officers  
23 or employees of a sponsor which is a  
24 service provider (other than a contract  
25 administrator) to the plan may be

1 members of the board if they con-  
2 stitute not more than 25 percent of  
3 the membership of the board and they  
4 do not provide services to the plan  
5 other than on behalf of the sponsor.

6 “(III) TREATMENT OF PRO-  
7 VIDERS OF MEDICAL CARE.—In the  
8 case of a sponsor which is an associa-  
9 tion whose membership consists pri-  
10 marily of providers of medical care,  
11 subclause (I) shall not apply in the  
12 case of any service provider described  
13 in subclause (I) who is a provider of  
14 medical care under the plan.

15 “(iii) CERTAIN PLANS EXCLUDED.—  
16 Clause (i) shall not apply to an association  
17 health plan which is in existence on the  
18 date of the enactment of the Small Busi-  
19 ness Health Fairness Act of 2009.

20 “(B) SOLE AUTHORITY.—The board has  
21 sole authority under the plan to approve appli-  
22 cations for participation in the plan and to con-  
23 tract with a service provider to administer the  
24 day-to-day affairs of the plan.

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

5               “(1) the requirements of subsection (a) and sec-  
6 tion 801(a) shall be deemed met if such require-  
7 ments would otherwise be met if the franchiser were  
8 deemed to be the sponsor referred to in section  
9 801(b), such network were deemed to be an associa-  
10 tion described in section 801(b), and each franchisee  
11 were deemed to be a member (of the association and  
12 the sponsor) referred to in section 801(b); and

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

15 The Secretary may by regulation define for purposes of  
16 this subsection the terms ‘franchiser’, ‘franchise network’,  
17 and ‘franchisee’.

18 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**  
19 **MENTS.**

20       “(a) COVERED EMPLOYERS AND INDIVIDUALS.—The  
21 requirements of this subsection are met with respect to  
22 an association health plan if, under the terms of the  
23 plan—

24               “(1) each participating employer must be—

25                       “(A) a member of the sponsor,

1 “(B) the sponsor, or

2 “(C) an affiliated member of the sponsor  
3 with respect to which the requirements of sub-  
4 section (b) are met,

5 except that, in the case of a sponsor which is a pro-  
6 fessional association or other individual-based asso-  
7 ciation, if at least one of the officers, directors, or  
8 employees of an employer, or at least one of the in-  
9 dividuals who are partners in an employer and who  
10 actively participates in the business, is a member or  
11 such an affiliated member of the sponsor, partici-  
12 pating employers may also include such employer;  
13 and

14 “(2) all individuals commencing coverage under  
15 the plan after certification under this part must  
16 be—

17 “(A) active or retired owners (including  
18 self-employed individuals), officers, directors, or  
19 employees of, or partners in, participating em-  
20 ployers; or

21 “(B) the beneficiaries of individuals de-  
22 scribed in subparagraph (A).

23 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-  
24 PLOYEES.—In the case of an association health plan in  
25 existence on the date of the enactment of the Small Busi-

1 ness Health Fairness Act of 2009, an affiliated member  
2 of the sponsor of the plan may be offered coverage under  
3 the plan as a participating employer only if—

4           “(1) the affiliated member was an affiliated  
5 member on the date of certification under this part;  
6 or

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

13           “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-  
14 quirements of this subsection are met with respect to an  
15 association health plan if, under the terms of the plan,  
16 no participating employer may provide health insurance  
17 coverage in the individual market for any employee not  
18 covered under the plan which is similar to the coverage  
19 contemporaneously provided to employees of the employer  
20 under the plan, if such exclusion of the employee from cov-  
21 erage under the plan is based on a health status-related  
22 factor with respect to the employee and such employee  
23 would, but for such exclusion on such basis, be eligible  
24 for coverage under the plan.

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

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

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

16           “(3) the applicable requirements of sections  
17 701, 702, and 703 are met with respect to the plan.

18 **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**  
19 **DOCUMENTS, CONTRIBUTION RATES, AND**  
20 **BENEFIT OPTIONS.**

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

24           “(1) CONTENTS OF GOVERNING INSTRU-  
25 MENTS.—The instruments governing the plan in-

1       clude a written instrument, meeting the require-  
2       ments of an instrument required under section  
3       402(a)(1), which—

4               “(A) provides that the board of trustees  
5       serves as the named fiduciary required for plans  
6       under section 402(a)(1) and serves in the ca-  
7       pacity of a plan administrator (referred to in  
8       section 3(16)(A));

9               “(B) provides that the sponsor of the plan  
10      is to serve as plan sponsor (referred to in sec-  
11      tion 3(16)(B)); and

12              “(C) incorporates the requirements of sec-  
13      tion 806.

14              “(2) CONTRIBUTION RATES MUST BE NON-  
15      DISCRIMINATORY.—

16              “(A) The contribution rates for any par-  
17      ticipating small employer do not vary on the  
18      basis of any health status-related factor in rela-  
19      tion to employees of such employer or their  
20      beneficiaries and do not vary on the basis of the  
21      type of business or industry in which such em-  
22      ployer is engaged.

23              “(B) Nothing in this title or any other pro-  
24      vision of law shall be construed to preclude an  
25      association health plan, or a health insurance

1 issuer offering health insurance coverage in  
2 connection with an association health plan,  
3 from—

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

6 “(ii) varying contribution rates for  
7 small employers in a State to the extent  
8 that such rates could vary using the same  
9 methodology employed in such State for  
10 regulating premium rates in the small  
11 group market with respect to health insur-  
12 ance coverage offered in connection with  
13 bona fide associations (within the meaning  
14 of section 2791(d)(3) of the Public Health  
15 Service Act),

16 subject to the requirements of section 702(b)  
17 relating to contribution rates.

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

24 “(4) MARKETING REQUIREMENTS.—

1           “(A) IN GENERAL.—If a benefit option  
2           which consists of health insurance coverage is  
3           offered under the plan, State-licensed insurance  
4           agents shall be used to distribute to small em-  
5           ployers coverage which does not consist of  
6           health insurance coverage in a manner com-  
7           parable to the manner in which such agents are  
8           used to distribute health insurance coverage.

9           “(B) STATE-LICENSED INSURANCE  
10          AGENTS.—For purposes of subparagraph (A),  
11          the term ‘State-licensed insurance agents’  
12          means one or more agents who are licensed in  
13          a State and are subject to the laws of such  
14          State relating to licensure, qualification, test-  
15          ing, examination, and continuing education of  
16          persons authorized to offer, sell, or solicit  
17          health insurance coverage in such State.

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

23          “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO  
24          DESIGN BENEFIT OPTIONS.—Subject to section 514(d),  
25          nothing in this part or any provision of State law (as de-

1 fined in section 514(e)(1)) shall be construed to preclude  
2 an association health plan, or a health insurance issuer  
3 offering health insurance coverage in connection with an  
4 association health plan, from exercising its sole discretion  
5 in selecting the specific items and services consisting of  
6 medical care to be included as benefits under such plan  
7 or coverage, except (subject to section 514) in the case  
8 of (1) any law to the extent that it is not preempted under  
9 section 731(a)(1) with respect to matters governed by sec-  
10 tion 711, 712, or 713, or (2) any law of the State with  
11 which filing and approval of a policy type offered by the  
12 plan was initially obtained to the extent that such law pro-  
13 hibits an exclusion of a specific disease from such cov-  
14 erage.

15 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**  
16 **FOR SOLVENCY FOR PLANS PROVIDING**  
17 **HEALTH BENEFITS IN ADDITION TO HEALTH**  
18 **INSURANCE COVERAGE.**

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

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

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

1           “(A) establishes and maintains reserves  
2 with respect to such additional benefit options,  
3 in amounts recommended by the qualified  
4 health actuary, consisting of—

5                   “(i) a reserve sufficient for unearned  
6 contributions;

7                   “(ii) a reserve sufficient for benefit li-  
8 abilities which have been incurred, which  
9 have not been satisfied, and for which risk  
10 of loss has not yet been transferred, and  
11 for expected administrative costs with re-  
12 spect to such benefit liabilities;

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

15                   “(iv) a reserve sufficient for a margin  
16 of error and other fluctuations, taking into  
17 account the specific circumstances of the  
18 plan; and

19           “(B) establishes and maintains aggregate  
20 and specific excess/stop loss insurance and sol-  
21 vency indemnification, with respect to such ad-  
22 ditional benefit options for which risk of loss  
23 has not yet been transferred, as follows:

24                   “(i) The plan shall secure aggregate  
25 excess/stop loss insurance for the plan with

1 an attachment point which is not greater  
2 than 125 percent of expected gross annual  
3 claims. The applicable authority may by  
4 regulation provide for upward adjustments  
5 in the amount of such percentage in speci-  
6 fied circumstances in which the plan spe-  
7 cifically provides for and maintains re-  
8 serves in excess of the amounts required  
9 under subparagraph (A).

10 “(ii) The plan shall secure specific ex-  
11 cess/stop loss insurance for the plan with  
12 an attachment point which is at least equal  
13 to an amount recommended by the plan’s  
14 qualified health actuary. The applicable  
15 authority may by regulation provide for ad-  
16 justments in the amount of such insurance  
17 in specified circumstances in which the  
18 plan specifically provides for and maintains  
19 reserves in excess of the amounts required  
20 under subparagraph (A).

21 “(iii) The plan shall secure indem-  
22 nification insurance for any claims which  
23 the plan is unable to satisfy by reason of  
24 a plan termination.

1 Any person issuing to a plan insurance described in clause  
2 (i), (ii), or (iii) of subparagraph (B) shall notify the Sec-  
3 retary of any failure of premium payment meriting can-  
4 cellation of the policy prior to undertaking such a cancella-  
5 tion. Any regulations prescribed by the applicable author-  
6 ity pursuant to clause (i) or (ii) of subparagraph (B) may  
7 allow for such adjustments in the required levels of excess/  
8 stop loss insurance as the qualified health actuary may  
9 recommend, taking into account the specific circumstances  
10 of the plan.

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

16 “(1) \$500,000, or

17 “(2) such greater amount (but not greater than  
18 \$2,000,000) as may be set forth in regulations pre-  
19 scribed by the applicable authority, considering the  
20 level of aggregate and specific excess/stop loss insur-  
21 ance provided with respect to such plan and other  
22 factors related to solvency risk, such as the plan’s  
23 projected levels of participation or claims, the nature  
24 of the plan’s liabilities, and the types of assets avail-  
25 able to assure that such liabilities are met.

1       “(c) ADDITIONAL REQUIREMENTS.—In the case of  
2 any association health plan described in subsection (a)(2),  
3 the applicable authority may provide such additional re-  
4 quirements relating to reserves, excess/stop loss insurance,  
5 and indemnification insurance as the applicable authority  
6 considers appropriate. Such requirements may be provided  
7 by regulation with respect to any such plan or any class  
8 of such plans.

9       “(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSUR-  
10 ANCE.—The applicable authority may provide for adjust-  
11 ments to the levels of reserves otherwise required under  
12 subsections (a) and (b) with respect to any plan or class  
13 of plans to take into account excess/stop loss insurance  
14 provided with respect to such plan or plans.

15       “(e) ALTERNATIVE MEANS OF COMPLIANCE.—The  
16 applicable authority may permit an association health plan  
17 described in subsection (a)(2) to substitute, for all or part  
18 of the requirements of this section (except subsection  
19 (a)(2)(B)(iii)), such security, guarantee, hold-harmless ar-  
20 rangement, or other financial arrangement as the applica-  
21 ble authority determines to be adequate to enable the plan  
22 to fully meet all its financial obligations on a timely basis  
23 and is otherwise no less protective of the interests of par-  
24 ticipants and beneficiaries than the requirements for  
25 which it is substituted. The applicable authority may take

1 into account, for purposes of this subsection, evidence pro-  
2 vided by the plan or sponsor which demonstrates an as-  
3 sumption of liability with respect to the plan. Such evi-  
4 dence may be in the form of a contract of indemnification,  
5 lien, bonding, insurance, letter of credit, recourse under  
6 applicable terms of the plan in the form of assessments  
7 of participating employers, security, or other financial ar-  
8 rangement.

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

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

13 “(A) IN GENERAL.—In the case of an as-  
14 sociation health plan described in subsection  
15 (a)(2), the requirements of this subsection are  
16 met if the plan makes payments into the Asso-  
17 ciation Health Plan Fund under this subpara-  
18 graph when they are due. Such payments shall  
19 consist of annual payments in the amount of  
20 \$5,000, and, in addition to such annual pay-  
21 ments, such supplemental payments as the Sec-  
22 retary may determine to be necessary under  
23 paragraph (2). Payments under this paragraph  
24 are payable to the Fund at the time determined  
25 by the Secretary. Initial payments are due in

1 advance of certification under this part. Pay-  
2 ments shall continue to accrue until a plan's as-  
3 sets are distributed pursuant to a termination  
4 procedure.

5 “(B) PENALTIES FOR FAILURE TO MAKE  
6 PAYMENTS.—If any payment is not made by a  
7 plan when it is due, a late payment charge of  
8 not more than 100 percent of the payment  
9 which was not timely paid shall be payable by  
10 the plan to the Fund.

11 “(C) CONTINUED DUTY OF THE SEC-  
12 RETARY.—The Secretary shall not cease to  
13 carry out the provisions of paragraph (2) on ac-  
14 count of the failure of a plan to pay any pay-  
15 ment when due.

16 “(2) PAYMENTS BY SECRETARY TO CONTINUE  
17 EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-  
18 DEMNIFICATION INSURANCE COVERAGE FOR CER-  
19 TAIN PLANS.—In any case in which the applicable  
20 authority determines that there is, or that there is  
21 reason to believe that there will be: (A) a failure to  
22 take necessary corrective actions under section  
23 809(a) with respect to an association health plan de-  
24 scribed in subsection (a)(2); or (B) a termination of  
25 such a plan under section 809(b) or 810(b)(8) (and,

1 if the applicable authority is not the Secretary, cer-  
2 tifies such determination to the Secretary), the Sec-  
3 retary shall determine the amounts necessary to  
4 make payments to an insurer (designated by the  
5 Secretary) to maintain in force excess/stop loss in-  
6 surance coverage or indemnification insurance cov-  
7 erage for such plan, if the Secretary determines that  
8 there is a reasonable expectation that, without such  
9 payments, claims would not be satisfied by reason of  
10 termination of such coverage. The Secretary shall, to  
11 the extent provided in advance in appropriation  
12 Acts, pay such amounts so determined to the insurer  
13 designated by the Secretary.

14 “(3) ASSOCIATION HEALTH PLAN FUND.—

15 “(A) IN GENERAL.—There is established  
16 on the books of the Treasury a fund to be  
17 known as the ‘Association Health Plan Fund’.  
18 The Fund shall be available for making pay-  
19 ments pursuant to paragraph (2). The Fund  
20 shall be credited with payments received pursu-  
21 ant to paragraph (1)(A), penalties received pur-  
22 suant to paragraph (1)(B); and earnings on in-  
23 vestments of amounts of the Fund under sub-  
24 paragraph (B).

1           “(B) INVESTMENT.—Whenever the Sec-  
2           retary determines that the moneys of the fund  
3           are in excess of current needs, the Secretary  
4           may request the investment of such amounts as  
5           the Secretary determines advisable by the Sec-  
6           retary of the Treasury in obligations issued or  
7           guaranteed by the United States.

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

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

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

20           “(B) which is guaranteed renewable; and

21           “(C) which allows for payment of pre-  
22           miums by any third party on behalf of the in-  
23           sured plan.

24           “(2) SPECIFIC EXCESS/STOP LOSS INSUR-  
25           ANCE.—The term ‘specific excess/stop loss insur-

1       ance’ means, in connection with an association  
2       health plan, a contract—

3               “(A) under which an insurer (meeting such  
4               minimum standards as the applicable authority  
5               may prescribe by regulation) provides for pay-  
6               ment to the plan with respect to claims under  
7               the plan in connection with a covered individual  
8               in excess of an amount or amounts specified in  
9               such contract in connection with such covered  
10              individual;

11             “(B) which is guaranteed renewable; and

12             “(C) which allows for payment of pre-  
13             miums by any third party on behalf of the in-  
14             sured plan.

15       “(h) INDEMNIFICATION INSURANCE.—For purposes  
16 of this section, the term ‘indemnification insurance’  
17 means, in connection with an association health plan, a  
18 contract—

19             “(1) under which an insurer (meeting such min-  
20             imum standards as the applicable authority may pre-  
21             scribe by regulation) provides for payment to the  
22             plan with respect to claims under the plan which the  
23             plan is unable to satisfy by reason of a termination  
24             pursuant to section 809(b) (relating to mandatory  
25             termination);

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

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

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

12          “(j) SOLVENCY STANDARDS WORKING GROUP.—

13           “(1) IN GENERAL.—Within 90 days after the  
14           date of the enactment of the Small Business Health  
15           Fairness Act of 2009, the applicable authority shall  
16           establish a Solvency Standards Working Group. In  
17           prescribing the initial regulations under this section,  
18           the applicable authority shall take into account the  
19           recommendations of such Working Group.

20           “(2) MEMBERSHIP.—The Working Group shall  
21           consist of not more than 15 members appointed by  
22           the applicable authority. The applicable authority  
23           shall include among persons invited to membership  
24           on the Working Group at least one of each of the  
25           following:

1           “(A) a representative of the National Asso-  
2           ciation of Insurance Commissioners;

3           “(B) a representative of the American  
4           Academy of Actuaries;

5           “(C) a representative of the State govern-  
6           ments, or their interests;

7           “(D) a representative of existing self-in-  
8           sured arrangements, or their interests;

9           “(E) a representative of associations of the  
10          type referred to in section 801(b)(1), or their  
11          interests; and

12          “(F) a representative of multiemployer  
13          plans that are group health plans, or their in-  
14          terests.

15   **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-  
16          LATED REQUIREMENTS.**

17          “(a) **FILING FEE.**—Under the procedure prescribed  
18          pursuant to section 802(a), an association health plan  
19          shall pay to the applicable authority at the time of filing  
20          an application for certification under this part a filing fee  
21          in the amount of \$5,000, which shall be available in the  
22          case of the Secretary, to the extent provided in appropria-  
23          tion Acts, for the sole purpose of administering the certifi-  
24          cation procedures applicable with respect to association  
25          health plans.

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

7           “(1) IDENTIFYING INFORMATION.—The names  
8 and addresses of—

9               “(A) the sponsor; and

10              “(B) the members of the board of trustees  
11 of the plan.

12           “(2) STATES IN WHICH PLAN INTENDS TO DO  
13 BUSINESS.—The States in which participants and  
14 beneficiaries under the plan are to be located and  
15 the number of them expected to be located in each  
16 such State.

17           “(3) BONDING REQUIREMENTS.—Evidence pro-  
18 vided by the board of trustees that the bonding re-  
19 quirements of section 412 will be met as of the date  
20 of the application or (if later) commencement of op-  
21 erations.

22           “(4) PLAN DOCUMENTS.—A copy of the docu-  
23 ments governing the plan (including any bylaws and  
24 trust agreements), the summary plan description,  
25 and other material describing the benefits that will

1 be provided to participants and beneficiaries under  
2 the plan.

3 “(5) AGREEMENTS WITH SERVICE PRO-  
4 VIDERS.—A copy of any agreements between the  
5 plan and contract administrators and other service  
6 providers.

7 “(6) FUNDING REPORT.—In the case of asso-  
8 ciation health plans providing benefits options in ad-  
9 dition to health insurance coverage, a report setting  
10 forth information with respect to such additional  
11 benefit options determined as of a date within the  
12 120-day period ending with the date of the applica-  
13 tion, including the following:

14 “(A) RESERVES.—A statement, certified  
15 by the board of trustees of the plan, and a  
16 statement of actuarial opinion, signed by a  
17 qualified health actuary, that all applicable re-  
18 quirements of section 806 are or will be met in  
19 accordance with regulations which the applica-  
20 ble authority shall prescribe.

21 “(B) ADEQUACY OF CONTRIBUTION  
22 RATES.—A statement of actuarial opinion,  
23 signed by a qualified health actuary, which sets  
24 forth a description of the extent to which con-  
25 tribution rates are adequate to provide for the

1 payment of all obligations and the maintenance  
2 of required reserves under the plan for the 12-  
3 month period beginning with such date within  
4 such 120-day period, taking into account the  
5 expected coverage and experience of the plan. If  
6 the contribution rates are not fully adequate,  
7 the statement of actuarial opinion shall indicate  
8 the extent to which the rates are inadequate  
9 and the changes needed to ensure adequacy.

10 “(C) CURRENT AND PROJECTED VALUE OF  
11 ASSETS AND LIABILITIES.—A statement of ac-  
12 tuarial opinion signed by a qualified health ac-  
13 tuary, which sets forth the current value of the  
14 assets and liabilities accumulated under the  
15 plan and a projection of the assets, liabilities,  
16 income, and expenses of the plan for the 12-  
17 month period referred to in subparagraph (B).  
18 The income statement shall identify separately  
19 the plan’s administrative expenses and claims.

20 “(D) COSTS OF COVERAGE TO BE  
21 CHARGED AND OTHER EXPENSES.—A state-  
22 ment of the costs of coverage to be charged, in-  
23 cluding an itemization of amounts for adminis-  
24 tration, reserves, and other expenses associated  
25 with the operation of the plan.

1                   “(E) OTHER INFORMATION.—Any other  
2                   information as may be determined by the appli-  
3                   cable authority, by regulation, as necessary to  
4                   carry out the purposes of this part.

5                   “(c) FILING NOTICE OF CERTIFICATION WITH  
6 STATES.—A certification granted under this part to an  
7 association health plan shall not be effective unless written  
8 notice of such certification is filed with the applicable  
9 State authority of each State in which at least 25 percent  
10 of the participants and beneficiaries under the plan are  
11 located. For purposes of this subsection, an individual  
12 shall be considered to be located in the State in which a  
13 known address of such individual is located or in which  
14 such individual is employed.

15                   “(d) NOTICE OF MATERIAL CHANGES.—In the case  
16 of any association health plan certified under this part,  
17 descriptions of material changes in any information which  
18 was required to be submitted with the application for the  
19 certification under this part shall be filed in such form  
20 and manner as shall be prescribed by the applicable au-  
21 thority by regulation. The applicable authority may re-  
22 quire by regulation prior notice of material changes with  
23 respect to specified matters which might serve as the basis  
24 for suspension or revocation of the certification.

1           “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-  
2 SOCIATION HEALTH PLANS.—An association health plan  
3 certified under this part which provides benefit options in  
4 addition to health insurance coverage for such plan year  
5 shall meet the requirements of section 103 by filing an  
6 annual report under such section which shall include infor-  
7 mation described in subsection (b)(6) with respect to the  
8 plan year and, notwithstanding section 104(a)(1)(A), shall  
9 be filed with the applicable authority not later than 90  
10 days after the close of the plan year (or on such later date  
11 as may be prescribed by the applicable authority). The ap-  
12 plicable authority may require by regulation such interim  
13 reports as it considers appropriate.

14           “(f) ENGAGEMENT OF QUALIFIED HEALTH ACTU-  
15 ARY.—The board of trustees of each association health  
16 plan which provides benefits options in addition to health  
17 insurance coverage and which is applying for certification  
18 under this part or is certified under this part shall engage,  
19 on behalf of all participants and beneficiaries, a qualified  
20 health actuary who shall be responsible for the preparation  
21 of the materials comprising information necessary to be  
22 submitted by a qualified health actuary under this part.  
23 The qualified health actuary shall utilize such assumptions  
24 and techniques as are necessary to enable such actuary

1 to form an opinion as to whether the contents of the mat-  
2 ters reported under this part—

3 “(1) are in the aggregate reasonably related to  
4 the experience of the plan and to reasonable expecta-  
5 tions; and

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

8 The opinion by the qualified health actuary shall be made  
9 with respect to, and shall be made a part of, the annual  
10 report.

11 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**  
12 **MINATION.**

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

19 “(1) provides to the participants and bene-  
20 ficiaries a written notice of intent to terminate stat-  
21 ing that such termination is intended and the pro-  
22 posed termination date;

23 “(2) develops a plan for winding up the affairs  
24 of the plan in connection with such termination in

1 a manner which will result in timely payment of all  
2 benefits for which the plan is obligated; and

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

5 Actions required under this section shall be taken in such  
6 form and manner as may be prescribed by the applicable  
7 authority by regulation.

8 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-  
9 NATION.**

10 “(a) ACTIONS TO AVOID DEPLETION OF RE-  
11 SERVES.—An association health plan which is certified  
12 under this part and which provides benefits other than  
13 health insurance coverage shall continue to meet the re-  
14 quirements of section 806, irrespective of whether such  
15 certification continues in effect. The board of trustees of  
16 such plan shall determine quarterly whether the require-  
17 ments of section 806 are met. In any case in which the  
18 board determines that there is reason to believe that there  
19 is or will be a failure to meet such requirements, or the  
20 applicable authority makes such a determination and so  
21 notifies the board, the board shall immediately notify the  
22 qualified health actuary engaged by the plan, and such  
23 actuary shall, not later than the end of the next following  
24 month, make such recommendations to the board for cor-  
25 rective action as the actuary determines necessary to en-

1 sure compliance with section 806. Not later than 30 days  
2 after receiving from the actuary recommendations for cor-  
3 rective actions, the board shall notify the applicable au-  
4 thority (in such form and manner as the applicable au-  
5 thority may prescribe by regulation) of such recommenda-  
6 tions of the actuary for corrective action, together with  
7 a description of the actions (if any) that the board has  
8 taken or plans to take in response to such recommenda-  
9 tions. The board shall thereafter report to the applicable  
10 authority, in such form and frequency as the applicable  
11 authority may specify to the board, regarding corrective  
12 action taken by the board until the requirements of section  
13 806 are met.

14 “(b) MANDATORY TERMINATION.—In any case in  
15 which—

16 “(1) the applicable authority has been notified  
17 under subsection (a) (or by an issuer of excess/stop  
18 loss insurance or indemnity insurance pursuant to  
19 section 806(a)) of a failure of an association health  
20 plan which is or has been certified under this part  
21 and is described in section 806(a)(2) to meet the re-  
22 quirements of section 806 and has not been notified  
23 by the board of trustees of the plan that corrective  
24 action has restored compliance with such require-  
25 ments; and



1 shall, upon notice to the plan, apply to the appropriate  
2 United States district court for appointment of the Sec-  
3 retary as trustee to administer the plan for the duration  
4 of the insolvency. The plan may appear as a party and  
5 other interested persons may intervene in the proceedings  
6 at the discretion of the court. The court shall appoint such  
7 Secretary trustee if the court determines that the trustee-  
8 ship is necessary to protect the interests of the partici-  
9 pants and beneficiaries or providers of medical care or to  
10 avoid any unreasonable deterioration of the financial con-  
11 dition of the plan. The trusteeship of such Secretary shall  
12 continue until the conditions described in the first sen-  
13 tence of this subsection are remedied or the plan is termi-  
14 nated.

15       “(b) POWERS AS TRUSTEE.—The Secretary, upon  
16 appointment as trustee under subsection (a), shall have  
17 the power—

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

21               “(2) to require the transfer of all (or any part)  
22 of the assets and records of the plan to the Sec-  
23 retary as trustee;

24               “(3) to invest any assets of the plan which the  
25 Secretary holds in accordance with the provisions of

1 the plan, regulations prescribed by the Secretary,  
2 and applicable provisions of law;

3 “(4) to require the sponsor, the plan adminis-  
4 trator, any participating employer, and any employee  
5 organization representing plan participants to fur-  
6 nish any information with respect to the plan which  
7 the Secretary as trustee may reasonably need in  
8 order to administer the plan;

9 “(5) to collect for the plan any amounts due the  
10 plan and to recover reasonable expenses of the trust-  
11 eeship;

12 “(6) to commence, prosecute, or defend on be-  
13 half of the plan any suit or proceeding involving the  
14 plan;

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

19 “(8) to terminate the plan (or provide for its  
20 termination in accordance with section 809(b)) and  
21 liquidate the plan assets, to restore the plan to the  
22 responsibility of the sponsor, or to continue the  
23 trusteeship;

1           “(9) to provide for the enrollment of plan par-  
2           ticipants and beneficiaries under appropriate cov-  
3           erage options; and

4           “(10) to do such other acts as may be nec-  
5           essary to comply with this title or any order of the  
6           court and to protect the interests of plan partici-  
7           pants and beneficiaries and providers of medical  
8           care.

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

12           “(1) the sponsor and plan administrator;

13           “(2) each participant;

14           “(3) each participating employer; and

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

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

1       “(e) OTHER PROCEEDINGS.—An application by the  
2 Secretary under this subsection may be filed notwith-  
3 standing the pendency in the same or any other court of  
4 any bankruptcy, mortgage foreclosure, or equity receiver-  
5 ship proceeding, or any proceeding to reorganize, conserve,  
6 or liquidate such plan or its property, or any proceeding  
7 to enforce a lien against property of the plan.

8       “(f) JURISDICTION OF COURT.—

9           “(1) IN GENERAL.—Upon the filing of an appli-  
10 cation for the appointment as trustee or the issuance  
11 of a decree under this section, the court to which the  
12 application is made shall have exclusive jurisdiction  
13 of the plan involved and its property wherever lo-  
14 cated with the powers, to the extent consistent with  
15 the purposes of this section, of a court of the United  
16 States having jurisdiction over cases under chapter  
17 11 of title 11, United States Code. Pending an adju-  
18 dication under this section such court shall stay, and  
19 upon appointment by it of the Secretary as trustee,  
20 such court shall continue the stay of, any pending  
21 mortgage foreclosure, equity receivership, or other  
22 proceeding to reorganize, conserve, or liquidate the  
23 plan, the sponsor, or property of such plan or spon-  
24 sor, and any other suit against any receiver, conser-  
25 vator, or trustee of the plan, the sponsor, or prop-

1       erty of the plan or sponsor. Pending such adjudica-  
2       tion and upon the appointment by it of the Sec-  
3       retary as trustee, the court may stay any proceeding  
4       to enforce a lien against property of the plan or the  
5       sponsor or any other suit against the plan or the  
6       sponsor.

7           “(2) VENUE.—An action under this section  
8       may be brought in the judicial district where the  
9       sponsor or the plan administrator resides or does  
10      business or where any asset of the plan is situated.  
11      A district court in which such action is brought may  
12      issue process with respect to such action in any  
13      other judicial district.

14      “(g) PERSONNEL.—In accordance with regulations  
15      which shall be prescribed by the Secretary, the Secretary  
16      shall appoint, retain, and compensate accountants, actu-  
17      aries, and other professional service personnel as may be  
18      necessary in connection with the Secretary’s service as  
19      trustee under this section.

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

21      “(a) IN GENERAL.—Notwithstanding section 514, a  
22      State may impose by law a contribution tax on an associa-  
23      tion health plan described in section 806(a)(2), if the plan  
24      commenced operations in such State after the date of the

1 enactment of the Small Business Health Fairness Act of  
2 2009.

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

7 “(1) such tax is computed by applying a rate to  
8 the amount of premiums or contributions, with re-  
9 spect to individuals covered under the plan who are  
10 residents of such State, which are received by the  
11 plan from participating employers located in such  
12 State or from such individuals;

13 “(2) the rate of such tax does not exceed the  
14 rate of any tax imposed by such State on premiums  
15 or contributions received by insurers or health main-  
16 tenance organizations for health insurance coverage  
17 offered in such State in connection with a group  
18 health plan;

19 “(3) such tax is otherwise nondiscriminatory;  
20 and

21 “(4) the amount of any such tax assessed on  
22 the plan is reduced by the amount of any tax or as-  
23 sessment otherwise imposed by the State on pre-  
24 miums, contributions, or both received by insurers or  
25 health maintenance organizations for health insur-

1       ance coverage, aggregate excess/stop loss insurance  
2       (as defined in section 806(g)(1)), specific excess/stop  
3       loss insurance (as defined in section 806(g)(2)),  
4       other insurance related to the provision of medical  
5       care under the plan, or any combination thereof pro-  
6       vided by such insurers or health maintenance organi-  
7       zations in such State in connection with such plan.

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

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

10               “(1) GROUP HEALTH PLAN.—The term ‘group  
11       health plan’ has the meaning provided in section  
12       733(a)(1) (after applying subsection (b) of this sec-  
13       tion).

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

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

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

22               “(5) APPLICABLE AUTHORITY.—The term ‘ap-  
23       plicable authority’ means the Secretary, except that,  
24       in connection with any exercise of the Secretary’s  
25       authority regarding which the Secretary is required

1 under section 506(d) to consult with a State, such  
2 term means the Secretary, in consultation with such  
3 State.

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

7 “(7) INDIVIDUAL MARKET.—

8 “(A) IN GENERAL.—The term ‘individual  
9 market’ means the market for health insurance  
10 coverage offered to individuals other than in  
11 connection with a group health plan.

12 “(B) TREATMENT OF VERY SMALL  
13 GROUPS.—

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

21 “(ii) STATE EXCEPTION.—Clause (i)  
22 shall not apply in the case of health insur-  
23 ance coverage offered in a State if such  
24 State regulates the coverage described in  
25 such clause in the same manner and to the

1 same extent as coverage in the small group  
2 market (as defined in section 2791(e)(5) of  
3 the Public Health Service Act) is regulated  
4 by such State.

5 “(8) PARTICIPATING EMPLOYER.—The term  
6 ‘participating employer’ means, in connection with  
7 an association health plan, any employer, if any indi-  
8 vidual who is an employee of such employer, a part-  
9 ner in such employer, or a self-employed individual  
10 who is such employer (or any dependent, as defined  
11 under the terms of the plan, of such individual) is  
12 or was covered under such plan in connection with  
13 the status of such individual as such an employee,  
14 partner, or self-employed individual in relation to the  
15 plan.

16 “(9) APPLICABLE STATE AUTHORITY.—The  
17 term ‘applicable State authority’ means, with respect  
18 to a health insurance issuer in a State, the State in-  
19 surance commissioner or official or officials des-  
20 ignated by the State to enforce the requirements of  
21 title XXVII of the Public Health Service Act for the  
22 State involved with respect to such issuer.

23 “(10) QUALIFIED HEALTH ACTUARY.—The  
24 term ‘qualified health actuary’ means an individual

1 who is a member of the American Academy of Actu-  
2 aries with expertise in health care.

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

5 “(A) a person who is otherwise eligible to  
6 be a member of the sponsor but who elects an  
7 affiliated status with the sponsor,

8 “(B) in the case of a sponsor with mem-  
9 bers which consist of associations, a person who  
10 is a member of any such association and elects  
11 an affiliated status with the sponsor, or

12 “(C) in the case of an association health  
13 plan in existence on the date of the enactment  
14 of the Small Business Health Fairness Act of  
15 2009, a person eligible to be a member of the  
16 sponsor or one of its member associations.

17 “(12) LARGE EMPLOYER.—The term ‘large em-  
18 ployer’ means, in connection with a group health  
19 plan with respect to a plan year, an employer who  
20 employed an average of at least 51 employees on  
21 business days during the preceding calendar year  
22 and who employs at least 2 employees on the first  
23 day of the plan year.

24 “(13) SMALL EMPLOYER.—The term ‘small em-  
25 ployer’ means, in connection with a group health

1 plan with respect to a plan year, an employer who  
2 is not a large employer.

3 “(b) RULES OF CONSTRUCTION.—

4 “(1) EMPLOYERS AND EMPLOYEES.—For pur-  
5 poses of determining whether a plan, fund, or pro-  
6 gram is an employee welfare benefit plan which is an  
7 association health plan, and for purposes of applying  
8 this title in connection with such plan, fund, or pro-  
9 gram so determined to be such an employee welfare  
10 benefit plan—

11 “(A) in the case of a partnership, the term  
12 ‘employer’ (as defined in section 3(5)) includes  
13 the partnership in relation to the partners, and  
14 the term ‘employee’ (as defined in section 3(6))  
15 includes any partner in relation to the partner-  
16 ship; and

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

21 “(2) PLANS, FUNDS, AND PROGRAMS TREATED  
22 AS EMPLOYEE WELFARE BENEFIT PLANS.—In the  
23 case of any plan, fund, or program which was estab-  
24 lished or is maintained for the purpose of providing  
25 medical care (through the purchase of insurance or

1 otherwise) for employees (or their dependents) cov-  
2 ered thereunder and which demonstrates to the Sec-  
3 retary that all requirements for certification under  
4 this part would be met with respect to such plan,  
5 fund, or program if such plan, fund, or program  
6 were a group health plan, such plan, fund, or pro-  
7 gram shall be treated for purposes of this title as an  
8 employee welfare benefit plan on and after the date  
9 of such demonstration.”.

10 (b) CONFORMING AMENDMENTS TO PREEMPTION  
11 RULES.—

12 (1) Section 514(b)(6) of such Act (29 U.S.C.  
13 1144(b)(6)) is amended by adding at the end the  
14 following new subparagraph:

15 “(E) The preceding subparagraphs of this paragraph  
16 do not apply with respect to any State law in the case  
17 of an association health plan which is certified under part  
18 8.”.

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

21 (A) in subsection (b)(4), by striking “Sub-  
22 section (a)” and inserting “Subsections (a) and  
23 (d)”;

24 (B) in subsection (b)(5), by striking “sub-  
25 section (a)” in subparagraph (A) and inserting

1 “subsection (a) of this section and subsections  
2 (a)(2)(B) and (b) of section 805”, and by strik-  
3 ing “subsection (a)” in subparagraph (B) and  
4 inserting “subsection (a) of this section or sub-  
5 section (a)(2)(B) or (b) of section 805”;

6 (C) by redesignating subsection (d) as sub-  
7 section (e); and

8 (D) by inserting after subsection (c) the  
9 following new subsection:

10 “(d)(1) Except as provided in subsection (b)(4), the  
11 provisions of this title shall supersede any and all State  
12 laws insofar as they may now or hereafter preclude, or  
13 have the effect of precluding, a health insurance issuer  
14 from offering health insurance coverage in connection with  
15 an association health plan which is certified under part  
16 8.

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

19 “(A) In any case in which health insurance cov-  
20 erage of any policy type is offered under an associa-  
21 tion health plan certified under part 8 to a partici-  
22 pating employer operating in such State, the provi-  
23 sions of this title shall supersede any and all laws  
24 of such State insofar as they may preclude a health  
25 insurance issuer from offering health insurance cov-

1 erage of the same policy type to other employers op-  
2 erating in the State which are eligible for coverage  
3 under such association health plan, whether or not  
4 such other employers are participating employers in  
5 such plan.

6 “(B) In any case in which health insurance cov-  
7 erage of any policy type is offered in a State under  
8 an association health plan certified under part 8 and  
9 the filing, with the applicable State authority (as de-  
10 fined in section 812(a)(9)), of the policy form in  
11 connection with such policy type is approved by such  
12 State authority, the provisions of this title shall su-  
13 persede any and all laws of any other State in which  
14 health insurance coverage of such type is offered, in-  
15 sofar as they may preclude, upon the filing in the  
16 same form and manner of such policy form with the  
17 applicable State authority in such other State, the  
18 approval of the filing in such other State.

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

23 “(A) providing solvency standards or similar  
24 standards regarding the adequacy of insurer capital,  
25 surplus, reserves, or contributions, or

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

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

5           “(5) For purposes of this subsection, the term ‘asso-  
6 ciation health plan’ has the meaning provided in section  
7 801(a), and the terms ‘health insurance coverage’, ‘par-  
8 ticipating employer’, and ‘health insurance issuer’ have  
9 the meanings provided such terms in section 812, respec-  
10 tively.”.

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

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

15           (B) in clause (ii), by inserting “and which  
16 does not provide medical care (within the mean-  
17 ing of section 733(a)(2)),” after “arrange-  
18 ment,” and by striking “title.” and inserting  
19 “title, and”; and

20           (C) by adding at the end the following new  
21 clause:

22           “(iii) subject to subparagraph (E), in the case  
23 of any other employee welfare benefit plan which is  
24 a multiple employer welfare arrangement and which  
25 provides medical care (within the meaning of section

1       733(a)(2)), any law of any State which regulates in-  
2       surance may apply.”.

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

5           (A) by striking “Nothing” and inserting  
6           “(1) Except as provided in paragraph (2), noth-  
7       ing”; and

8           (B) by adding at the end the following new  
9       paragraph:

10       “(2) Nothing in any other provision of law enacted  
11       on or after the date of the enactment of the Small Busi-  
12       ness Health Fairness Act of 2009 shall be construed to  
13       alter, amend, modify, invalidate, impair, or supersede any  
14       provision of this title, except by specific cross-reference to  
15       the affected section.”.

16       (c) PLAN SPONSOR.—Section 3(16)(B) of such Act  
17       (29 U.S.C. 102(16)(B)) is amended by adding at the end  
18       the following new sentence: “Such term also includes a  
19       person serving as the sponsor of an association health plan  
20       under part 8.”.

21       (d) DISCLOSURE OF SOLVENCY PROTECTIONS RE-  
22       LATED TO SELF-INSURED AND FULLY INSURED OPTIONS  
23       UNDER ASSOCIATION HEALTH PLANS.—Section 102(b)  
24       of such Act (29 U.S.C. 102(b)) is amended by adding at  
25       the end the following: “An association health plan shall

1 include in its summary plan description, in connection  
2 with each benefit option, a description of the form of sol-  
3 vency or guarantee fund protection secured pursuant to  
4 this Act or applicable State law, if any.”.

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

7 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-  
8 CATION OF SELF-INSURED ASSOCIATION HEALTH  
9 PLANS.—Not later than January 1, 2012, the Secretary  
10 of Labor shall report to the Committee on Education and  
11 the Workforce of the House of Representatives and the  
12 Committee on Health, Education, Labor, and Pensions of  
13 the Senate the effect association health plans have had,  
14 if any, on reducing the number of uninsured individuals.

15 (g) CLERICAL AMENDMENT.—The table of contents  
16 in section 1 of the Employee Retirement Income Security  
17 Act of 1974 is amended by inserting after the item relat-  
18 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.”.

1 **SEC. 233. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
2 **PLOYER ARRANGEMENTS.**

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

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

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

19 “(iii)(I) in any case in which the benefit re-  
20 ferred to in subparagraph (A) consists of medical  
21 care (as defined in section 812(a)(2)), the deter-  
22 mination of whether a trade or business is under  
23 ‘common control’ with another trade or business  
24 shall be determined under regulations of the Sec-

1       retary applying principles consistent and coextensive  
2       with the principles applied in determining whether  
3       employees of two or more trades or businesses are  
4       treated as employed by a single employer under sec-  
5       tion 4001(b), except that, for purposes of this para-  
6       graph, an interest of greater than 25 percent may  
7       not be required as the minimum interest necessary  
8       for common control, or

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

10              (3) by redesignating clauses (iv) and (v) as  
11              clauses (v) and (vi), respectively; and

12              (4) by inserting after clause (iii) the following  
13              new clause:

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

1       ees of participating employers and who are covered  
2       under the arrangement,”.

3       **SEC. 234. ENFORCEMENT PROVISIONS RELATING TO ASSO-**  
4       **CIATION HEALTH PLANS.**

5       (a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL  
6 MISREPRESENTATIONS.—Section 501 of the Employee  
7 Retirement Income Security Act of 1974 (29 U.S.C. 1131)  
8 is amended—

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

10              (2) by adding at the end the following new sub-  
11      section:

12      “(b) Any person who willfully falsely represents, to  
13 any employee, any employee’s beneficiary, any employer,  
14 the Secretary, or any State, a plan or other arrangement  
15 established or maintained for the purpose of offering or  
16 providing any benefit described in section 3(1) to employ-  
17 ees or their beneficiaries as—

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

20              “(2) having been established or maintained  
21      under or pursuant to one or more collective bar-  
22      gaining agreements which are reached pursuant to  
23      collective bargaining described in section 8(d) of the  
24      National Labor Relations Act (29 U.S.C. 158(d)) or  
25      paragraph Fourth of section 2 of the Railway Labor

1 Act (45 U.S.C. 152, paragraph Fourth) or which are  
2 reached pursuant to labor-management negotiations  
3 under similar provisions of State public employee re-  
4 lations laws; or

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

7 shall, upon conviction, be imprisoned not more than 5  
8 years, be fined under title 18, United States Code, or  
9 both.”.

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

13 “(n) ASSOCIATION HEALTH PLAN CEASE AND DE-  
14 SIST ORDERS.—

15 “(1) IN GENERAL.—Subject to paragraph (2),  
16 upon application by the Secretary showing the oper-  
17 ation, promotion, or marketing of an association  
18 health plan (or similar arrangement providing bene-  
19 fits consisting of medical care (as defined in section  
20 733(a)(2))) that—

21 “(A) is not certified under part 8, is sub-  
22 ject under section 514(b)(6) to the insurance  
23 laws of any State in which the plan or arrange-  
24 ment offers or provides benefits, and is not li-

1 censed, registered, or otherwise approved under  
2 the insurance laws of such State; or

3 “(B) is an association health plan certified  
4 under part 8 and is not operating in accordance  
5 with the requirements under part 8 for such  
6 certification,

7 a district court of the United States shall enter an  
8 order requiring that the plan or arrangement cease  
9 activities.

10 “(2) EXCEPTION.—Paragraph (1) shall not  
11 apply in the case of an association health plan or  
12 other arrangement if the plan or arrangement shows  
13 that—

14 “(A) all benefits under it referred to in  
15 paragraph (1) consist of health insurance cov-  
16 erage; and

17 “(B) with respect to each State in which  
18 the plan or arrangement offers or provides ben-  
19 efits, the plan or arrangement is operating in  
20 accordance with applicable State laws that are  
21 not superseded under section 514.

22 “(3) ADDITIONAL EQUITABLE RELIEF.—The  
23 court may grant such additional equitable relief, in-  
24 cluding any relief available under this title, as it  
25 deems necessary to protect the interests of the pub-



1           “(A) the Secretary’s authority under sec-  
2           tions 502 and 504 to enforce the requirements  
3           for certification under part 8; and

4           “(B) the Secretary’s authority to certify  
5           association health plans under part 8 in accord-  
6           ance with regulations of the Secretary applica-  
7           ble to certification under part 8.

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

14               “(A) in the case of a plan which provides  
15               health insurance coverage (as defined in section  
16               812(a)(3)), such State shall be the State with  
17               which filing and approval of a policy type of-  
18               fered by the plan was initially obtained, and

19               “(B) in any other case, the Secretary shall  
20               take into account the places of residence of the  
21               participants and beneficiaries under the plan  
22               and the State in which the trust is main-  
23               tained.”.

1 **SEC. 236. EFFECTIVE DATE AND TRANSITIONAL AND**  
2 **OTHER RULES.**

3 (a) **EFFECTIVE DATE.**—The amendments made by  
4 this subtitle shall take effect 1 year after the date of the  
5 enactment of this Act. The Secretary of Labor shall first  
6 issue all regulations necessary to carry out the amend-  
7 ments made by this subtitle within 1 year after the date  
8 of the enactment of this Act.

9 (b) **TREATMENT OF CERTAIN EXISTING HEALTH**  
10 **BENEFITS PROGRAMS.**—

11 (1) **IN GENERAL.**—In any case in which, as of  
12 the date of the enactment of this Act, an arrange-  
13 ment is maintained in a State for the purpose of  
14 providing benefits consisting of medical care for the  
15 employees and beneficiaries of its participating em-  
16 ployers, at least 200 participating employers make  
17 contributions to such arrangement, such arrange-  
18 ment has been in existence for at least 10 years, and  
19 such arrangement is licensed under the laws of one  
20 or more States to provide such benefits to its par-  
21 ticipating employers, upon the filing with the appli-  
22 cable authority (as defined in section 812(a)(5) of  
23 the Employee Retirement Income Security Act of  
24 1974 (as amended by this subtitle)) by the arrange-  
25 ment of an application for certification of the ar-

1        arrangement under part 8 of subtitle B of title I of  
2        such Act—

3                (A) such arrangement shall be deemed to  
4                be a group health plan for purposes of title I  
5                of such Act;

6                (B) the requirements of sections 801(a)  
7                and 803(a) of the Employee Retirement Income  
8                Security Act of 1974 shall be deemed met with  
9                respect to such arrangement;

10               (C) the requirements of section 803(b) of  
11               such Act shall be deemed met, if the arrange-  
12               ment is operated by a board of directors  
13               which—

14                        (i) is elected by the participating em-  
15                        ployers, with each employer having one  
16                        vote; and

17                        (ii) has complete fiscal control over  
18                        the arrangement and which is responsible  
19                        for all operations of the arrangement;

20                (D) the requirements of section 804(a) of  
21                such Act shall be deemed met with respect to  
22                such arrangement; and

23                (E) the arrangement may be certified by  
24                any applicable authority with respect to its op-

1           erations in any State only if it operates in such  
2           State on the date of certification.

3           The provisions of this subsection shall cease to apply  
4           with respect to any such arrangement at such time  
5           after the date of the enactment of this Act as the  
6           applicable requirements of this subsection are not  
7           met with respect to such arrangement.

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

17       **TITLE III—INTERSTATE MARKET**  
18       **FOR HEALTH INSURANCE**

19       **SEC. 301. COOPERATIVE GOVERNING OF INDIVIDUAL**  
20       **HEALTH INSURANCE COVERAGE.**

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

1           **“PART D—COOPERATIVE GOVERNING OF**  
2           **INDIVIDUAL HEALTH INSURANCE COVERAGE**

3           **“SEC. 2795. DEFINITIONS.**

4           “In this part:

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

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

1 is deemed to be doing business in that secondary  
2 State.

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

9 “(4) INDIVIDUAL HEALTH INSURANCE COV-  
10 ERAGE.—The term ‘individual health insurance cov-  
11 erage’ means health insurance coverage offered in  
12 the individual market, as defined in section  
13 2791(e)(1).

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

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

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

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

6           “(7) COVERED LAWS.—

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

11           “(i) individual health insurance cov-  
12 erage issued by a health insurance issuer;

13           “(ii) the offer, sale, rating (including  
14 medical underwriting), renewal, and  
15 issuance of individual health insurance cov-  
16 erage to an individual;

17           “(iii) the provision to an individual in  
18 relation to individual health insurance cov-  
19 erage of health care and insurance related  
20 services;

21           “(iv) the provision to an individual in  
22 relation to individual health insurance cov-  
23 erage of management, operations, and in-  
24 vestment activities of a health insurance  
25 issuer; and

1           “(v) the provision to an individual in  
2           relation to individual health insurance cov-  
3           erage of loss control and claims adminis-  
4           tration for a health insurance issuer with  
5           respect to liability for which the issuer pro-  
6           vides insurance.

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

14          “(8) STATE.—The term ‘State’ means only the  
15          50 States and the District of Columbia.

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

19               “(A) Knowingly misrepresenting to claim-  
20               ants and insured individuals relevant facts or  
21               policy provisions relating to coverage at issue.

22               “(B) Failing to acknowledge with reason-  
23               able promptness pertinent communications with  
24               respect to claims arising under policies.

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

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

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

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

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

19          “(H) A pattern or practice of attempting  
20          to settle or settling claims for less than the  
21          amount that a reasonable person would believe  
22          the insured individual or his or her beneficiary  
23          was entitled by reference to written or printed  
24          advertising material accompanying or made  
25          part of an application.

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

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

9           “(K) Attempting to cancel a policy in less  
10          time than that prescribed in the policy or by the  
11          law of the primary State.

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

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

23                         “(i) An application for the issuance or  
24                         renewal of an insurance policy or reinsur-  
25                         ance contract.

1                   “(ii) The rating of an insurance policy  
2 or reinsurance contract.

3                   “(iii) A claim for payment or benefit  
4 pursuant to an insurance policy or reinsur-  
5 ance contract.

6                   “(iv) Premiums paid on an insurance  
7 policy or reinsurance contract.

8                   “(v) Payments made in accordance  
9 with the terms of an insurance policy or  
10 reinsurance contract.

11                   “(vi) A document filed with the com-  
12 missioner or the chief insurance regulatory  
13 official of another jurisdiction.

14                   “(vii) The financial condition of an in-  
15 surer or reinsurer.

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

21                   “(ix) The issuance of written evidence  
22 of insurance.

23                   “(x) The reinstatement of an insur-  
24 ance policy.

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

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

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

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

17          “(a) IN GENERAL.—The covered laws of the primary  
18          State shall apply to individual health insurance coverage  
19          offered by a health insurance issuer in the primary State  
20          and in any secondary State, but only if the coverage and  
21          issuer comply with the conditions of this section with re-  
22          spect to the offering of coverage in any secondary State.

23          “(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-  
24          ONDARY STATE.—Except as provided in this section, a  
25          health insurance issuer with respect to its offer, sale, rat-

1 ing (including medical underwriting), renewal, and  
2 issuance of individual health insurance coverage in any  
3 secondary State is exempt from any covered laws of the  
4 secondary State (and any rules, regulations, agreements,  
5 or orders sought or issued by such State under or related  
6 to such covered laws) to the extent that such laws would—

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

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

16                 “(B) to register with and designate the  
17                 State insurance commissioner as its agent solely  
18                 for the purpose of receiving service of legal doc-  
19                 uments or process;

20                 “(C) to submit to an examination of its fi-  
21                 nancial condition by the State insurance com-  
22                 missioner in any State in which the issuer is  
23                 doing business to determine the issuer’s finan-  
24                 cial condition, if—

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

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

12          “(D) to comply with a lawful order  
13          issued—

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

19               “(ii) in a voluntary dissolution pro-  
20               ceeding;

21          “(E) to comply with an injunction issued  
22          by a court of competent jurisdiction, upon a pe-  
23          tition by the State insurance commissioner al-  
24          leging that the issuer is in hazardous financial  
25          condition;

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

6           “(G) to comply with any State law regard-  
7           ing fraud and abuse (as defined in section  
8           2795(10)), except that if the State seeks an in-  
9           junction regarding the conduct described in this  
10          subparagraph, such injunction must be obtained  
11          from a court of competent jurisdiction;

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

15          “(I) to comply with the applicable require-  
16          ments for independent review under section  
17          2798 with respect to coverage offered in the  
18          State;

19          “(2) require any individual health insurance  
20          coverage issued by the issuer to be countersigned by  
21          an insurance agent or broker residing in that Sec-  
22          ondary State; or

23          “(3) otherwise discriminate against the issuer  
24          issuing insurance in both the primary State and in  
25          any secondary State.

1           “(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A  
2 health insurance issuer shall provide the following notice,  
3 in 12-point bold type, in any insurance coverage offered  
4 in a secondary State under this part by such a health in-  
5 surance issuer and at renewal of the policy, with the 5  
6 blank spaces therein being appropriately filled with the  
7 name of the health insurance issuer, the name of primary  
8 State, the name of the secondary State, the name of the  
9 secondary State, and the name of the secondary State, re-  
10 spectively, for the coverage concerned:

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

1           “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS  
2 AND PREMIUM INCREASES.—

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

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

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

18           “(2) CONSTRUCTION.—Nothing in paragraph  
19 (1) shall be construed to prohibit a health insurance  
20 issuer—

21           “(A) from terminating or discontinuing  
22 coverage or a class of coverage in accordance  
23 with subsections (b) and (c) of section 2742;

1           “(B) from raising premium rates for all  
2 policy holders within a class based on claims ex-  
3 perience;

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

9           “(i) are disclosed to the consumer in  
10 the insurance contract;

11           “(ii) are based on specific wellness ac-  
12 tivities that are not applicable to all indi-  
13 viduals; and

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

16           “(D) from reinstating lapsed coverage; or

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

21           “(e) PRIOR OFFERING OF POLICY IN PRIMARY  
22 STATE.—A health insurance issuer may not offer for sale  
23 individual health insurance coverage in a secondary State  
24 unless that coverage is currently offered for sale in the  
25 primary State.

1           “(f) LICENSING OF AGENTS OR BROKERS FOR  
2 HEALTH INSURANCE ISSUERS.—Any State may require  
3 that a person acting, or offering to act, as an agent or  
4 broker for a health insurance issuer with respect to the  
5 offering of individual health insurance coverage obtain a  
6 license from that State, with commissions or other com-  
7 pensation subject to the provisions of the laws of that  
8 State, except that a State may not impose any qualifica-  
9 tion or requirement which discriminates against a non-  
10 resident agent or broker.

11           “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-  
12 SURANCE COMMISSIONER.—Each health insurance issuer  
13 issuing individual health insurance coverage in both pri-  
14 mary and secondary States shall submit—

15           “(1) to the insurance commissioner of each  
16 State in which it intends to offer such coverage, be-  
17 fore it may offer individual health insurance cov-  
18 erage in such State—

19           “(A) a copy of the plan of operation or fea-  
20 sibility study or any similar statement of the  
21 policy being offered and its coverage (which  
22 shall include the name of its primary State and  
23 its principal place of business);

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

1           “(C) written notice from the issuer of the  
2           issuer’s compliance with all the laws of the pri-  
3           mary State; and

4           “(2) to the insurance commissioner of each sec-  
5           ondary State in which it offers individual health in-  
6           surance coverage, a copy of the issuer’s quarterly fi-  
7           nancial statement submitted to the primary State,  
8           which statement shall be certified by an independent  
9           public accountant and contain a statement of opin-  
10          ion on loss and loss adjustment expense reserves  
11          made by—

12                   “(A) a member of the American Academy  
13                   of Actuaries; or

14                   “(B) a qualified loss reserve specialist.

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

18                   “(1) the solicitation or sale of individual health  
19                   insurance coverage by a health insurance issuer to  
20                   any person or group who is not eligible for such in-  
21                   surance; or

22                   “(2) the solicitation or sale of individual health  
23                   insurance coverage that violates the requirements of  
24                   the law of a secondary State which are described in

1       subparagraphs (A) through (H) of section  
2       2796(b)(1).

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

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

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

16               “(2) COURTS OF COMPETENT JURISDICTION.—

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

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

24       “(l) GENERALLY APPLICABLE LAWS.—Nothing in  
25       this section shall be construed to affect the applicability

1 of State laws generally applicable to persons or corpora-  
2 tions.

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

16 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**  
17 **BEFORE ISSUER MAY SELL INTO SECONDARY**  
18 **STATES.**

19       “A health insurance issuer may not offer, sell, or  
20 issue individual health insurance coverage in a secondary  
21 State if the State insurance commissioner does not use  
22 a risk-based capital formula for the determination of cap-  
23 ital and surplus requirements for all health insurance  
24 issuers.

1 **“SEC. 2798. LIMITATION ON INDIVIDUAL PURCHASE IN SEC-**  
2 **ONDARY STATE.**

3 “Effective beginning two years after the date of en-  
4 actment of this part, an individual in a State may not  
5 buy individual health insurance coverage in a secondary  
6 State if the premium for individual health insurance in  
7 the primary State (with respect to the individual) exceeds  
8 the national average premium by 10 percent or more.

9 **“SEC. 2799. INDEPENDENT EXTERNAL APPEALS PROCE-**  
10 **DURES.**

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

15 “(1) both the secondary State and the primary  
16 State have legislation or regulations in place estab-  
17 lishing an independent review process for individuals  
18 who are covered by individual health insurance cov-  
19 erage, or

20 “(2) in any case in which the requirements of  
21 subparagraph (A) are not met with respect to the ei-  
22 ther of such States, the issuer provides an inde-  
23 pendent review mechanism substantially identical (as  
24 determined by the applicable State authority of such  
25 State) to that prescribed in the ‘Health Carrier Ex-  
26 ternal Review Model Act’ of the National Association

1 of Insurance Commissioners for all individuals who  
2 purchase insurance coverage under the terms of this  
3 part, except that, under such mechanism, the review  
4 is conducted by an independent medical reviewer, or  
5 a panel of such reviewers, with respect to whom the  
6 requirements of subsection (b) are met.

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

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

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

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

22 “(C) compensation provided by the issuer  
23 to each reviewer is consistent with paragraph  
24 (6).

1           “(2) LICENSURE AND EXPERTISE.—Each inde-  
2           pendent medical reviewer shall be a physician  
3           (allopathic or osteopathic) or health care profes-  
4           sional who—

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

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

11           “(3) INDEPENDENCE.—

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

15                           “(i) not be a related party (as defined  
16                           in paragraph (7));

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

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

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

1           “(i) prohibit an individual, solely on  
2           the basis of affiliation with the issuer,  
3           from serving as an independent medical re-  
4           viewer if—

5                   “(I) a non-affiliated individual is  
6                   not reasonably available;

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

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

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

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

1           “(iii) prohibit receipt of compensation  
2           by an independent medical reviewer from  
3           an entity if the compensation is provided  
4           consistent with paragraph (6).

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

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

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

19           “(ii) by a non-physician health care  
20           professional, the reviewer, or at least 1  
21           member of the review panel, shall be a  
22           practicing non-physician health care pro-  
23           fessional of the same or similar specialty  
24           as the non-physician health care profes-  
25           sional who, acting within the appropriate

1 scope of practice within the State in which  
2 the service is provided or rendered, typi-  
3 cally treats the condition, makes the diag-  
4 nosis, or provides the type of treatment  
5 under review.

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

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

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

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

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

23 “(7) RELATED PARTY DEFINED.—For purposes  
24 of this section, the term ‘related party’ means, with

1       respect to a denial of a claim under a coverage relat-  
2       ing to an enrollee, any of the following:

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

5               “(B) The enrollee (or authorized represent-  
6               ative).

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

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

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

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

19              “(8) DEFINITIONS.—For purposes of this sub-  
20              section:

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

1           “(B) HEALTH CARE PROFESSIONAL.—The  
2           term ‘health care professional’ means an indi-  
3           vidual who is licensed, accredited, or certified  
4           under State law to provide specified health care  
5           services and who is operating within the scope  
6           of such licensure, accreditation, or certification.

7   **“SEC. 2800. ENFORCEMENT.**

8           “(a) IN GENERAL.—Subject to subsection (b), with  
9           respect to specific individual health insurance coverage the  
10          primary State for such coverage has sole jurisdiction to  
11          enforce the primary State’s covered laws in the primary  
12          State and any secondary State.

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

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

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

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

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

7 (c) GAO ONGOING STUDY AND REPORTS.—

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

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

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

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

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

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

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

6           (d) SEVERABILITY.—If any provision of the section  
7           or the application of such provision to any person or cir-  
8           cumstance is held to be unconstitutional, the remainder  
9           of this section and the application of the provisions of such  
10          to any other person or circumstance shall not be affected.

## 11                   **TITLE IV—SAFETY NET** 12                   **REFORMS**

### 13   **SEC. 401. REQUIRING OUTREACH AND COVERAGE BEFORE** 14                   **EXPANSION OF ELIGIBILITY.**

15          (a) STATE PLAN REQUIRED TO SPECIFY HOW IT  
16          WILL ACHIEVE COVERAGE FOR 90 PERCENT OF TAR-  
17          GETED LOW-INCOME CHILDREN.—

18               (1) IN GENERAL.—Section 2102(a) of the So-  
19          cial Security Act (42 U.S.C. 1397bb(a)) is amend-  
20          ed—

21                   (A) in paragraph (6), by striking “and” at  
22                   the end;

23                   (B) in paragraph (7), by striking the pe-  
24                   riod at the end and inserting “; and”; and

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

3 “(8) how the eligibility and benefits provided  
4 for under the plan for each fiscal year (beginning  
5 with fiscal year 2011) will allow for the State’s an-  
6 nual funding allotment to cover at least 90 percent  
7 of the eligible targeted low-income children in the  
8 State.”.

9 (2) EFFECTIVE DATE.—The amendments made  
10 by paragraph (1) shall apply to State child health  
11 plans for fiscal years beginning with fiscal year  
12 2011.

13 (b) LIMITATION ON PROGRAM EXPANSIONS UNTIL  
14 LOWEST INCOME ELIGIBLE INDIVIDUALS ENROLLED.—  
15 Section 2105(c) of such Act (42 U.S.C. 1397dd(c)) is  
16 amended by adding at the end the following new para-  
17 graph:

18 “(8) LIMITATION ON INCREASED COVERAGE OF  
19 HIGHER INCOME CHILDREN.—For child health as-  
20 sistance furnished in a fiscal year beginning with fis-  
21 cal year 2011:

22 “(A) NO PAYMENT FOR CHILDREN WITH  
23 FAMILY INCOME ABOVE 300 PERCENT OF POV-  
24 ERTY LINE.—Payment shall not be made under  
25 this section for child health assistance for a tar-

1           geted low-income child in a family the income  
2           of which exceeds 300 percent of the poverty line  
3           applicable to a family of the size involved.

4           “(B) SPECIAL RULES FOR PAYMENT FOR  
5           CHILDREN WITH FAMILY INCOME ABOVE 200  
6           PERCENT OF POVERTY LINE.—In the case of  
7           child health assistance for a targeted low-in-  
8           come child in a family the income of which ex-  
9           ceeds 200 percent (but does not exceed 300  
10          percent) of the poverty line applicable to a fam-  
11          ily of the size involved no payment shall be  
12          made under this section for such assistance un-  
13          less the State demonstrates to the satisfaction  
14          of the Secretary that—

15                 “(i) the State has met the 90 percent  
16                 retrospective coverage test specified in sub-  
17                 paragraph (C)(i) for the previous fiscal  
18                 year; and

19                 “(ii) the State will meet the 90 per-  
20                 cent prospective coverage test specified in  
21                 subparagraph (C)(ii) for the fiscal year.

22          “(C) 90 PERCENT COVERAGE TESTS.—

23                 “(i) RETROSPECTIVE TEST.—The 90  
24                 percent retrospective coverage test speci-  
25                 fied in this clause is, for a State for a fis-

1 cal year, that on average during the fiscal  
2 year, the State has enrolled under this title  
3 or title XIX at least 90 percent of the indi-  
4 viduals residing in the State who—

5 “(I) are children under 19 years  
6 of age (or are pregnant women) and  
7 are eligible for medical assistance  
8 under title XIX; or

9 “(II) are targeted low-income  
10 children whose family income does not  
11 exceed 200 percent of the poverty line  
12 and who are eligible for child health  
13 assistance under this title.

14 “(ii) PROSPECTIVE TEST.—The 90  
15 percent prospective test specified in this  
16 clause is, for a State for a fiscal year, that  
17 on average during the fiscal year, the State  
18 will enroll under this title or title XIX at  
19 least 90 percent of the individuals residing  
20 in the State who—

21 “(I) are children under 19 years  
22 of age (or are pregnant women) and  
23 are eligible for medical assistance  
24 under title XIX; or

1                   “(II) are targeted low-income  
2                   children whose family income does not  
3                   exceed such percent of the poverty  
4                   line (in excess of 200 percent) as the  
5                   State elects consistent with this para-  
6                   graph and who are eligible for child  
7                   health assistance under this title.

8                   “(D) GRANDFATHER.—Subparagraphs (A)  
9                   and (B) shall not apply to the provision of child  
10                  health assistance—

11                  “(i) to a targeted low-income child  
12                  who is enrolled for child health assistance  
13                  under this title as of September 30, 2008;

14                  “(ii) to a pregnant woman who is en-  
15                  rolled for assistance under this title as of  
16                  September 30, 2009, through the comple-  
17                  tion of the post-partum period following  
18                  completion of her pregnancy; and

19                  “(iii) for items and services furnished  
20                  before October 1, 2010, to an individual  
21                  who is not a targeted low-income child and  
22                  who is enrolled for assistance under this  
23                  title as of September 30, 2009.

24                  “(E) TREATMENT OF PREGNANT  
25                  WOMEN.—In this paragraph and sections

1           2102(a)(8) and 2104(a)(2), the term ‘targeted  
2           low-income child’ includes an individual under  
3           age 19, including the period from conception to  
4           birth, who is eligible for child health assistance  
5           under this title by virtue of the definition of the  
6           term ‘child’ under section 457.10 of title 42,  
7           Code of Federal Regulations.’’.

8           (c) STANDARDIZATION OF INCOME DETERMINA-  
9 TIONS.—

10           (1) IN GENERAL.—Section 2110(d) of such Act  
11           (42 U.S.C. 1397jj) is amended by adding at the end  
12           the following new subsection:

13           “(d) STANDARDIZATION OF INCOME DETERMINA-  
14 TIONS.—In determining family income under this title (in-  
15 cluding in the case of a State child health plan that pro-  
16 vides health benefits coverage in the manner described in  
17 section 2101(a)(2)), a State shall base such determination  
18 on gross income (including amounts that would be in-  
19 cluded in gross income if they were not exempt from in-  
20 come taxation) and may only take into consideration such  
21 income disregards as the Secretary shall develop.’’.

22           (2) EFFECTIVE DATE.—(A) Subject to subpara-  
23           graph (B), the amendment made by paragraph (1)  
24           shall apply to determinations (and redeterminations)  
25           of income made on or after April 1, 2010.

1           (B) In the case of a State child health plan  
2           under title XXI of the Social Security Act which the  
3           Secretary of Health and Human Services determines  
4           requires State legislation (other than legislation ap-  
5           propriating funds) in order for the plan to meet the  
6           additional requirement imposed by the amendment  
7           made by paragraph (1), the State child health plan  
8           shall not be regarded as failing to comply with the  
9           requirements of such title solely on the basis of its  
10          failure to meet this additional requirement before  
11          the first day of the first calendar quarter beginning  
12          after the close of the first regular session of the  
13          State legislature that begins after the date of the en-  
14          actment of this Act. For purposes of the previous  
15          sentence, in the case of a State that has a 2-year  
16          legislative session, each year of such session shall be  
17          deemed to be a separate regular session of the State  
18          legislature.

19 **SEC. 402. EASING ADMINISTRATIVE BARRIERS TO STATE**  
20                                   **COOPERATION WITH EMPLOYER-SPONSORED**  
21                                   **INSURANCE COVERAGE.**

22          (a) **REQUIRING SOME COVERAGE FOR EMPLOYER-**  
23 **SPONSORED INSURANCE.—**

1           (1) IN GENERAL.—Section 2102(a) of the So-  
2           cial Security Act (42 U.S.C. 1397b(a)), as amended  
3           by section 401(a), is amended—

4                   (A) in paragraph (7), by striking “and” at  
5           the end;

6                   (B) in paragraph (8), by striking the pe-  
7           riod at the end and inserting “; and”; and

8                   (C) by adding at the end the following new  
9           paragraph:

10           “(9) effective for plan years beginning on or  
11           after October 1, 2010, how the plan will provide for  
12           child health assistance with respect to targeted low-  
13           income children covered under a group health  
14           plan.”.

15           (2) EFFECTIVE DATE.—The amendment made  
16           by paragraph (1) shall apply beginning with fiscal  
17           year 2011.

18           (b) FEDERAL FINANCIAL PARTICIPATION FOR EM-  
19           PLOYER-SPONSORED INSURANCE.—Section 2105 of such  
20           Act (42 U.S.C. 1397d) is amended—

21                   (1) in subsection (a)(1)(C), by inserting before  
22           the semicolon at the end the following: “and, subject  
23           to paragraph (3)(C), in the form of payment of the  
24           premiums for coverage under a group health plan  
25           that includes coverage of targeted low-income chil-

1       dren and benefits supplemental to such coverage”;  
2       and

3               (2) by amending paragraph (3) of subsection  
4       (c) to read as follows:

5               “(3) PURCHASE OF EMPLOYER-SPONSORED IN-  
6       SURANCE.—

7               “(A) IN GENERAL.—Payment may be  
8       made to a State under subsection (a)(1)(C),  
9       subject to the provisions of this paragraph, for  
10       the purchase of family coverage under a group  
11       health plan that includes coverage of targeted  
12       low-income children unless such coverage would  
13       otherwise substitute for coverage that would be  
14       provided to such children but for the purchase  
15       of family coverage.

16               “(B) WAIVER OF CERTAIN PROVISIONS.—  
17       With respect to coverage described in subpara-  
18       graph (A)—

19               “(i) notwithstanding section 2102, no  
20       minimum benefits requirement (other than  
21       those otherwise applicable with respect to  
22       services referred to in section 2102(a)(7))  
23       under this title shall apply; and

1           “(ii) no limitation on beneficiary cost-  
2           sharing otherwise applicable under this  
3           title or title XIX shall apply.

4           “(C) REQUIRED PROVISION OF SUPPLE-  
5           MENTAL BENEFITS.—If the coverage described  
6           in subparagraph (A) does not provide coverage  
7           for the services referred to in section  
8           2102(a)(7), the State child health plan shall  
9           provide coverage of such services as supple-  
10          mental benefits.

11          “(D) LIMITATION ON FFP.—The amount  
12          of the payment under paragraph (1)(C) for cov-  
13          erage described in subparagraph (A) (and sup-  
14          plemental benefits under subparagraph (C) for  
15          individuals so covered) during a fiscal year may  
16          not exceed the product of—

17                 “(i) the national per capita expendi-  
18                 ture under this title (taking into account  
19                 both Federal and State expenditures) for  
20                 the previous fiscal year (as determined by  
21                 the Secretary using the best available  
22                 data);

23                 “(ii) the enhanced FMAP for the  
24                 State and fiscal year involved; and

1 “(iii) the number of targeted low-in-  
2 come children for whom such coverage is  
3 provided.

4 “(E) VOLUNTARY ENROLLMENT.—A State  
5 child health plan—

6 “(i) may not require a targeted low-  
7 income child to enroll in coverage described  
8 in subparagraph (A) in order to obtain  
9 child health assistance under this title;

10 “(ii) before providing such child  
11 health assistance for such coverage of a  
12 child, shall make available (which may be  
13 through an Internet website or other  
14 means including the State transparency  
15 plan portal established under section 901  
16 of the Siding with America’s Patients Act)  
17 to the parent or guardian of the child in-  
18 formation on the coverage available under  
19 this title, including benefits and cost-shar-  
20 ing; and

21 “(iii) shall provide at least one oppor-  
22 tunity per fiscal year for beneficiaries to  
23 switch coverage under this title from cov-  
24 erage described in subparagraph (A) to the

1 coverage that is otherwise made available  
2 under this title.

3 “(F) INFORMATION ON COVERAGE OP-  
4 TIONS.—A State child health plan shall—

5 “(i) describe how the State will notify  
6 potential beneficiaries of coverage de-  
7 scribed in subparagraph (A);

8 “(ii) provide such notification in writ-  
9 ing at least during the initial application  
10 for enrollment under this title and during  
11 redeterminations of eligibility if the indi-  
12 vidual was enrolled before October 1, 2010;  
13 and

14 “(iii) post a description of these cov-  
15 erage options on any official website that  
16 may be established by the State in connec-  
17 tion with the plan, including the State  
18 transparency plan portal established under  
19 section 901 of the Siding with America’s  
20 Patients Act.

21 “(G) SEMIANNUAL VERIFICATION OF COV-  
22 ERAGE.—If coverage described in subparagraph  
23 (A) is provided under a group health plan with  
24 respect to a targeted low-income child, the  
25 State child health plan shall provide for the col-

1           lection, at least once every six months, of proof  
2           from the plan that the child is enrolled in such  
3           coverage.

4           “(H) RULE OF CONSTRUCTION.—Nothing  
5           in this section is to be construed to prohibit a  
6           State from—

7                   “(i) offering wrap around benefits in  
8                   order for a group health plan to meet any  
9                   State-established minimum benefit require-  
10                  ments;

11                   “(ii) establishing a cost-effectiveness  
12                   test to qualify for coverage under such a  
13                   plan;

14                   “(iii) establishing limits on beneficiary  
15                   cost-sharing under such a plan;

16                   “(iv) paying all or part of a bene-  
17                   ficiary’s cost-sharing requirements under  
18                   such a plan;

19                   “(v) paying less than the full cost of  
20                   the employee’s share of the premium under  
21                   such a plan, including prorating the cost of  
22                   the premium to pay for only what the  
23                   State determines is the portion of the pre-  
24                   mium that covers targeted low-income chil-  
25                   dren;

1           “(vi) using State funds to pay for  
2           benefits above the Federal upper limit es-  
3           tablished under subparagraph (C);

4           “(vii) allowing beneficiaries enrolled in  
5           group health plans from changing plans to  
6           another coverage option available under  
7           this title at any time; or

8           “(viii) providing any guidance or in-  
9           formation it deems appropriate in order to  
10          help beneficiaries make an informed deci-  
11          sion regarding the option to enroll in cov-  
12          erage described in subparagraph (A).

13          “(I) GROUP HEALTH PLAN DEFINED.—In  
14          this paragraph, the term ‘group health plan’  
15          has the meaning given such term in section  
16          2791(a)(1) of the Public Health Service Act (42  
17          U.S.C. 300gg–91(a)(1)).”.

18          (c) APPLICATION UNDER MEDICAID.—The Secretary  
19          of Health and Human Services shall provide for the appli-  
20          cation of the amendments made by subsections (a) and  
21          (b) under the Medicaid program under title XIX of the  
22          Social Security Act in the same manner as such amend-  
23          ments apply to SCHIP under title XXI of such Act.

1 **SEC. 403. IMPROVING BENEFICIARY CHOICE IN SCHIP.**

2 (a) **REQUIRING OFFERING OF ALTERNATIVE COV-**  
3 **ERAGE OPTIONS.**—Section 2102 of the Social Security Act  
4 (42 U.S.C. 1397b), as amended by sections 401(a) and  
5 402(a), is amended—

6 (1) in subsection (a)—

7 (A) in paragraph (8), by striking “and” at  
8 the end;

9 (B) in paragraph (9), by striking the pe-  
10 riod at the end and inserting “; and”; and

11 (C) by adding at the end the following new  
12 paragraph:

13 “(10) effective for plan years beginning on or  
14 after October 1, 2010, how the plan will provide for  
15 child health assistance with respect to targeted low-  
16 income children through alternative coverage options  
17 in accordance with subsection (e).”; and

18 (2) by adding at the end the following new sub-  
19 section:

20 “(e) **ALTERNATIVE COVERAGE OPTIONS.**—

21 “(1) **IN GENERAL.**—Effective October 1, 2010,  
22 a State child health plan shall provide for the offer-  
23 ing of any qualified alternative coverage that a  
24 qualified entity seeks to offer to targeted low-income  
25 children through the plan in the State.

1           “(2) APPLICATION OF UNIFORM FINANCIAL  
2           LIMITATION FOR ALL ALTERNATIVE COVERAGE OP-  
3           TIONS.—With respect to all qualified alternative cov-  
4           erage offered in a State, the State child health plan  
5           shall establish a uniform dollar limitation on the per  
6           capita monthly amount that will be paid by the  
7           State to the qualified entity with respect to such  
8           coverage provided to a targeted low-income child.  
9           Such limitation may not be less than 90 percent of  
10          the per capita monthly payment made for coverage  
11          offered under the State child health plan that is not  
12          in the form of an alternative coverage option. Noth-  
13          ing in this paragraph shall be construed—

14                 “(A) as requiring a State to provide for  
15                 the full payment of premiums for qualified al-  
16                 ternative coverage;

17                 “(B) as preventing a State from charging  
18                 additional premiums to cover the difference be-  
19                 tween the cost of qualified alternative coverage  
20                 and the amount of such payment limitation; or

21                 “(C) as preventing a State from using its  
22                 own funds to provide a dollar limitation that ex-  
23                 ceeds the Federal financial participation as lim-  
24                 ited under section 2105(c)(10).

25           “(3) TREATMENT OF LOW COST COVERAGE.—

1           “(A) IN GENERAL.—Except as provided in  
2           subparagraph (B), if the uniform dollar limita-  
3           tion under paragraph (2) exceeds the premium  
4           for qualified alternative coverage for an en-  
5           rollee, then such excess shall be refunded to the  
6           Federal and State governments in the same  
7           proportion as is otherwise applicable to recov-  
8           ered funds under this title.

9           “(B) EXCEPTION FOR HIGH DEDUCTIBLE  
10          HEALTH PLANS.—In the case of coverage under  
11          a high deductible health plan, the excess de-  
12          scribed in subparagraph (A) shall be deposited  
13          into a health savings account established with  
14          respect to such plan.

15          “(4) EXEMPTION.—A State is not subject to  
16          the requirement of paragraph (1) if the State child  
17          health plan provides, as of the date of the enactment  
18          of this subsection, for a cash out or health savings  
19          account type option for those enrolled under the  
20          plan.

21          “(5) QUALIFIED ALTERNATIVE COVERAGE DE-  
22          FINED.—In this section, the term ‘qualified alter-  
23          native coverage’ means health insurance coverage  
24          that—

1           “(A) meets the coverage requirements of  
2           section 2103 (other than cost-sharing require-  
3           ments of such section); and

4           “(B) is offered by a qualified insurer, and  
5           not directly by the State.

6           “(6) QUALIFIED INSURER DEFINED.—In this  
7           section, the term ‘qualified insurer’ means, with re-  
8           spect to a State, an entity that is licensed to offer  
9           health insurance coverage in the State.”.

10          (b) FEDERAL FINANCIAL PARTICIPATION FOR  
11 QUALIFIED ALTERNATIVE COVERAGE.—Section 2105 of  
12 such Act (42 U.S.C. 1397d) is amended—

13           (1) in subsection (a)(1)(C), as amended by sec-  
14           tion 402(b), by inserting before the semicolon at the  
15           end the following: “and, subject to paragraph  
16           (8)(C), in the form of payment of the premiums for  
17           coverage for qualified alternative coverage”; and

18           (2) in subsection (c), by adding at the end the  
19           following new paragraph:

20           “(12) PURCHASE OF QUALIFIED ALTERNATIVE  
21           COVERAGE.—

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 qualified alternative coverage.

1           “(B) WAIVER OF CERTAIN PROVISIONS.—  
2           With respect to coverage described in subpara-  
3           graph (A), no limitation on beneficiary cost-  
4           sharing otherwise applicable under this title or  
5           title XIX shall apply.

6           “(C) LIMITATION ON FFP.—The amount of  
7           the payment under paragraph (1)(C) for cov-  
8           erage described in subparagraph (A) during a  
9           fiscal year in the aggregate for all such cov-  
10          erage in the State may not exceed the product  
11          of—

12                   “(i) the national per capita expendi-  
13                   ture under this title (taking into account  
14                   both Federal and State expenditures) for  
15                   the previous fiscal year (as determined by  
16                   the Secretary using the best available  
17                   data);

18                   “(ii) the enhanced FMAP for the  
19                   State and fiscal year involved; and

20                   “(iii) the number of targeted low-in-  
21                   come children for whom such coverage is  
22                   provided.

23           “(D) VOLUNTARY ENROLLMENT.—A State  
24          child health plan—

1 “(i) may not require a targeted low-  
2 income child to enroll in coverage described  
3 in subparagraph (A) in order to obtain  
4 child health assistance under this title;

5 “(ii) before providing such child  
6 health assistance for such coverage of a  
7 child, shall make available (which may be  
8 through an Internet website or other  
9 means) to the parent or guardian of the  
10 child information on the coverage available  
11 under this title, including benefits and  
12 cost-sharing; and

13 “(iii) shall provide at least one oppor-  
14 tunity per fiscal year for beneficiaries to  
15 switch coverage under this title from cov-  
16 erage described in subparagraph (A) to the  
17 coverage that is otherwise made available  
18 under this title.

19 “(E) INFORMATION ON COVERAGE OP-  
20 TIONS.—A State child health plan shall—

21 “(i) describe how the State will notify  
22 potential beneficiaries of coverage de-  
23 scribed in subparagraph (A);

24 “(ii) provide such notification in writ-  
25 ing at least during the initial application

1 for enrollment under this title and during  
2 redeterminations of eligibility if the indi-  
3 vidual was enrolled before October 1, 2010;  
4 and

5 “(iii) post a description of these cov-  
6 erage options on any official website that  
7 may be established by the State in connec-  
8 tion with the plan.

9 “(F) RULE OF CONSTRUCTION.—Nothing  
10 in this section is to be construed to prohibit a  
11 State from—

12 “(i) establishing limits on beneficiary  
13 cost-sharing under such alternative cov-  
14 erage;

15 “(ii) paying all or part of a bene-  
16 ficiary’s cost-sharing requirements under  
17 such coverage;

18 “(iii) paying less than the full cost of  
19 a child’s share of the premium under such  
20 coverage, insofar as the premium for such  
21 coverage exceeds the limitation established  
22 by the State under subparagraph (C);

23 “(iv) using State funds to pay for  
24 benefits above the Federal upper limit es-  
25 tablished under subparagraph (C); or

1           “(v) providing any guidance or infor-  
2           mation it deems appropriate in order to  
3           help beneficiaries make an informed deci-  
4           sion regarding the option to enroll in cov-  
5           erage described in subparagraph (A).”.

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. 404. LIABILITY PROTECTIONS FOR HEALTH CENTER**  
13 **VOLUNTEER PRACTITIONERS.**

14           (a) IN GENERAL.—Section 224 of the Public Health  
15 Service Act (42 U.S.C. 233) is amended—

16           (1) in subsection (g)(1)(A)—

17                   (A) in the first sentence, by striking “or  
18                   employee” and inserting “employee, or (subject  
19                   to subsection (k)(4)) volunteer practitioner”;  
20                   and

21                   (B) in the second sentence, by inserting  
22                   “and subsection (k)(4)” after “subject to para-  
23                   graph (5)”; and

24           (2) in each of subsections (g), (i), (j), (k), (l),  
25           and (m)—

1 (A) by striking the term “employee, or  
2 contractor” each place such term appears and  
3 inserting “employee, volunteer practitioner, or  
4 contractor”;

5 (B) by striking the term “employee, and  
6 contractor” each place such term appears and  
7 inserting “employee, volunteer practitioner, and  
8 contractor”;

9 (C) by striking the term “employee, or any  
10 contractor” each place such term appears and  
11 inserting “employee, volunteer practitioner, or  
12 contractor”; and

13 (D) by striking the term “employees, or  
14 contractors” each place such term appears and  
15 inserting “employees, volunteer practitioners, or  
16 contractors”.

17 (b) **APPLICABILITY; DEFINITION.**—Section 224(k) of  
18 the Public Health Service Act (42 U.S.C. 233(k)) is  
19 amended by adding at the end the following paragraph:

20 “(4)(A) Subsections (g) through (m) apply with re-  
21 spect to volunteer practitioners beginning with the first  
22 fiscal year for which an appropriations Act provides that  
23 amounts in the fund under paragraph (2) are available  
24 with respect to such practitioners.

1 “(B) For purposes of subsections (g) through (m),  
2 the term ‘volunteer practitioner’ means a practitioner who,  
3 with respect to an entity described in subsection (g)(4),  
4 meets the following conditions:

5 “(i) In the State involved, the practitioner is a  
6 licensed physician, a licensed clinical psychologist, or  
7 other licensed or certified health care practitioner.

8 “(ii) At the request of such entity, the practi-  
9 tioner provides services to patients of the entity, at  
10 a site at which the entity operates or at a site des-  
11 ignated by the entity. The weekly number of hours  
12 of services provided to the patients by the practi-  
13 tioner is not a factor with respect to meeting condi-  
14 tions under this subparagraph.

15 “(iii) The practitioner does not for the provision  
16 of such services receive any compensation from such  
17 patients, from the entity, or from third-party payors  
18 (including reimbursement under any insurance pol-  
19 icy or health plan, or under any Federal or State  
20 health benefits program).”.

21 **SEC. 405. LIABILITY PROTECTIONS FOR HEALTH CENTER**  
22 **PRACTITIONERS PROVIDING SERVICES IN**  
23 **EMERGENCY AREAS.**

24 Section 224(g) of the Public Health Service Act (42  
25 U.S.C. 233(g)) is amended—

1 (1) in paragraph (1)(B)(ii), by striking “sub-  
2 paragraph (C)” and inserting “subparagraph (C)  
3 and paragraph (6)”; and

4 (2) by adding at the end the following para-  
5 graph:

6 “(6)(A) Subject to subparagraph (C), paragraph  
7 (1)(B)(ii) applies to health services provided to individuals  
8 who are not patients of the entity involved if, as deter-  
9 mined under criteria issued by the Secretary, the following  
10 conditions are met:

11 “(i) The services are provided by a contractor,  
12 volunteer practitioner (as defined in subsection  
13 (k)(4)(B)), or employee of the entity who is a physi-  
14 cian or other licensed or certified health care practi-  
15 tioner and who is otherwise deemed to be an em-  
16 ployee for purposes of paragraph (1)(A) when pro-  
17 viding services with respect to the entity.

18 “(ii) The services are provided in an emergency  
19 area (as defined in subparagraph (D)), with respect  
20 to a public health emergency or major disaster de-  
21 scribed in subparagraph (D), and during the period  
22 for which such emergency or disaster is determined  
23 or declared, respectively.

24 “(iii) The services of the contractor, volunteer  
25 practitioner, or employee (referred to in this para-

1 graph as the ‘out-of-area practitioner’) are provided  
2 under an arrangement with—

3 “(I) an entity that is deemed to be an em-  
4 ployee for purposes of paragraph (1)(A) and  
5 that serves the emergency area involved (re-  
6 ferred to in this paragraph as an ‘emergency-  
7 area entity’); or

8 “(II) a Federal agency that has respon-  
9 sibilities regarding the provision of health serv-  
10 ices in such area during the emergency.

11 “(iv) The purposes of the arrangement are—

12 “(I) to coordinate, to the extent prac-  
13 ticable, the provision of health services in the  
14 emergency area by the out-of-area practitioner  
15 with the provision of services by the emergency-  
16 area entity, or by the Federal agency, as the  
17 case may be;

18 “(II) to identify a location in the emer-  
19 gency area to which such practitioner should re-  
20 port for purposes of providing health services,  
21 and to identify an individual or individuals in  
22 the area to whom the practitioner should report  
23 for such purposes; and

1           “(III) to verify the identity of the practi-  
2           tioner and that the practitioner is licensed or  
3           certified by one or more of the States.

4           “(v) With respect to the licensure or certifi-  
5           cation of health care practitioners, the provision of  
6           services by the out-of-area practitioner in the emer-  
7           gency area is not a violation of the law of the State  
8           in which the area is located.

9           “(B) In issuing criteria under subparagraph (A), the  
10          Secretary shall take into account the need to rapidly enter  
11          into arrangements under such subparagraph in order to  
12          provide health services in emergency areas promptly after  
13          the emergency begins.

14          “(C) Subparagraph (A) applies with respect to an act  
15          or omission of an out-of-area practitioner only to the ex-  
16          tent that the practitioner is not immune from liability for  
17          such act or omission under the Volunteer Protection Act  
18          of 1997.

19          “(D) For purposes of this paragraph, the term ‘emer-  
20          gency area’ means a geographic area for which—

21                 “(i) the Secretary has made a determination  
22                 under section 319 that a public health emergency  
23                 exists; or

24                 “(ii) a presidential declaration of major disaster  
25                 has been issued under section 401 of the Robert T.

1       Stafford Disaster Relief and Emergency Assistance  
2       Act.”.

3       **TITLE V—MEDICAL LIABILITY**  
4       **AND UNCOMPENSATED CARE**  
5       **REFORMS**

6       **SEC. 501. SHORT TITLE.**

7       This title may be cited as the “Help Efficient, Acces-  
8       sible, Low-cost, Timely Healthcare (HEALTH) Act of  
9       2009”.

10      **SEC. 502. FINDINGS AND PURPOSE.**

11      (a) FINDINGS.—

12           (1) EFFECT ON HEALTH CARE ACCESS AND  
13           COSTS.—Congress finds that our current civil justice  
14           system is adversely affecting patient access to health  
15           care services, better patient care, and cost-efficient  
16           health care, in that the health care liability system  
17           is a costly and ineffective mechanism for resolving  
18           claims of health care liability and compensating in-  
19           jured patients, and is a deterrent to the sharing of  
20           information among health care professionals which  
21           impedes efforts to improve patient safety and quality  
22           of care.

23           (2) EFFECT ON INTERSTATE COMMERCE.—

24           Congress finds that the health care and insurance  
25           industries are industries affecting interstate com-

1 merce and the health care liability litigation systems  
2 existing throughout the United States are activities  
3 that affect interstate commerce by contributing to  
4 the high costs of health care and premiums for  
5 health care liability insurance purchased by health  
6 care system providers.

7 (3) EFFECT ON FEDERAL SPENDING.—Con-  
8 gress finds that the health care liability litigation  
9 systems existing throughout the United States have  
10 a significant effect on the amount, distribution, and  
11 use of Federal funds because of—

12 (A) the large number of individuals who  
13 receive health care benefits under programs op-  
14 erated or financed by the Federal Government;

15 (B) the large number of individuals who  
16 benefit because of the exclusion from Federal  
17 taxes of the amounts spent to provide them  
18 with health insurance benefits; and

19 (C) the large number of health care pro-  
20 viders who provide items or services for which  
21 the Federal Government makes payments.

22 (b) PURPOSE.—It is the purpose of this title to imple-  
23 ment reasonable, comprehensive, and effective health care  
24 liability reforms designed to—

1           (1) improve the availability of health care serv-  
2           ices in cases in which health care liability actions  
3           have been shown to be a factor in the decreased  
4           availability of services;

5           (2) reduce the incidence of “defensive medi-  
6           cine” and lower the cost of health care liability in-  
7           surance, all of which contribute to the escalation of  
8           health care costs;

9           (3) ensure that persons with meritorious health  
10          care injury claims receive fair and adequate com-  
11          pensation, including reasonable noneconomic dam-  
12          ages;

13          (4) improve the fairness and cost-effectiveness  
14          of our current health care liability system to resolve  
15          disputes over, and provide compensation for, health  
16          care liability by reducing uncertainty in the amount  
17          of compensation provided to injured individuals; and

18          (5) provide an increased sharing of information  
19          in the health care system which will reduce unin-  
20          tended injury and improve patient care.

21 **SEC. 503. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.**

22          The time for the commencement of a health care law-  
23          suit shall be 3 years after the date of manifestation of  
24          injury or 1 year after the claimant discovers, or through  
25          the use of reasonable diligence should have discovered, the

1 injury, whichever occurs first. In no event shall the time  
2 for commencement of a health care lawsuit exceed 3 years  
3 after the date of manifestation of injury unless tolled for  
4 any of the following—

5 (1) upon proof of fraud;

6 (2) intentional concealment; or

7 (3) the presence of a foreign body, which has no  
8 therapeutic or diagnostic purpose or effect, in the  
9 person of the injured person. Actions by a minor  
10 shall be commenced within 3 years from the date of  
11 the alleged manifestation of injury except that ac-  
12 tions by a minor under the full age of 6 years shall  
13 be commenced within 3 years of manifestation of in-  
14 jury or prior to the minor's 8th birthday, whichever  
15 provides a longer period. Such time limitation shall  
16 be tolled for minors for any period during which a  
17 parent or guardian and a health care provider or  
18 health care organization have committed fraud or  
19 collusion in the failure to bring an action on behalf  
20 of the injured minor.

21 **SEC. 504. COMPENSATING PATIENT INJURY.**

22 (a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL  
23 ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any  
24 health care lawsuit, nothing in this title shall limit a claim-

1 ant's recovery of the full amount of the available economic  
2 damages, notwithstanding the limitation in subsection (b).

3 (b) ADDITIONAL NONECONOMIC DAMAGES.—In any  
4 health care lawsuit, the amount of noneconomic damages,  
5 if available, may be as much as \$250,000, regardless of  
6 the number of parties against whom the action is brought  
7 or the number of separate claims or actions brought with  
8 respect to the same injury.

9 (c) NO DISCOUNT OF AWARD FOR NONECONOMIC  
10 DAMAGES.—For purposes of applying the limitation in  
11 subsection (b), future noneconomic damages shall not be  
12 discounted to present value. The jury shall not be in-  
13 formed about the maximum award for noneconomic dam-  
14 ages. An award for noneconomic damages in excess of  
15 \$250,000 shall be reduced either before the entry of judg-  
16 ment, or by amendment of the judgment after entry of  
17 judgment, and such reduction shall be made before ac-  
18 counting for any other reduction in damages required by  
19 law. If separate awards are rendered for past and future  
20 noneconomic damages and the combined awards exceed  
21 \$250,000, the future noneconomic damages shall be re-  
22 duced first.

23 (d) FAIR SHARE RULE.—In any health care lawsuit,  
24 each party shall be liable for that party's several share  
25 of any damages only and not for the share of any other

1 person. Each party shall be liable only for the amount of  
2 damages allocated to such party in direct proportion to  
3 such party's percentage of responsibility. Whenever a  
4 judgment of liability is rendered as to any party, a sepa-  
5 rate judgment shall be rendered against each such party  
6 for the amount allocated to such party. For purposes of  
7 this section, the trier of fact shall determine the propor-  
8 tion of responsibility of each party for the claimant's  
9 harm.

10 **SEC. 505. MAXIMIZING PATIENT RECOVERY.**

11 (a) COURT SUPERVISION OF SHARE OF DAMAGES  
12 ACTUALLY PAID TO CLAIMANTS.—In any health care law-  
13 suit, the court shall supervise the arrangements for pay-  
14 ment of damages to protect against conflicts of interest  
15 that may have the effect of reducing the amount of dam-  
16 ages awarded that are actually paid to claimants. In par-  
17 ticular, in any health care lawsuit in which the attorney  
18 for a party claims a financial stake in the outcome by vir-  
19 tue of a contingent fee, the court shall have the power  
20 to restrict the payment of a claimant's damage recovery  
21 to such attorney, and to redirect such damages to the  
22 claimant based upon the interests of justice and principles  
23 of equity. In no event shall the total of all contingent fees  
24 for representing all claimants in a health care lawsuit ex-  
25 ceed the following limits:

1           (1) 40 percent of the first \$50,000 recovered by  
2           the claimant(s).

3           (2)  $33\frac{1}{3}$  percent of the next \$50,000 recovered  
4           by the claimant(s).

5           (3) 25 percent of the next \$500,000 recovered  
6           by the claimant(s).

7           (4) 15 percent of any amount by which the re-  
8           covery by the claimant(s) is in excess of \$600,000.

9           (b) **APPLICABILITY.**—The limitations in this section  
10          shall apply whether the recovery is by judgment, settle-  
11          ment, mediation, arbitration, or any other form of alter-  
12          native dispute resolution. In a health care lawsuit involv-  
13          ing a minor or incompetent person, a court retains the  
14          authority to authorize or approve a fee that is less than  
15          the maximum permitted under this section. The require-  
16          ment for court supervision in the first two sentences of  
17          subsection (a) applies only in civil actions.

18          **SEC. 506. ADDITIONAL HEALTH BENEFITS.**

19          In any health care lawsuit involving injury or wrong-  
20          ful death, any party may introduce evidence of collateral  
21          source benefits. If a party elects to introduce such evi-  
22          dence, any opposing party may introduce evidence of any  
23          amount paid or contributed or reasonably likely to be paid  
24          or contributed in the future by or on behalf of the oppos-  
25          ing party to secure the right to such collateral source bene-

1 fits. No provider of collateral source benefits shall recover  
2 any amount against the claimant or receive any lien or  
3 credit against the claimant's recovery or be equitably or  
4 legally subrogated to the right of the claimant in a health  
5 care lawsuit involving injury or wrongful death. This sec-  
6 tion shall apply to any health care lawsuit that is settled  
7 as well as a health care lawsuit that is resolved by a fact  
8 finder. This section shall not apply to section 1862(b) (42  
9 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C.  
10 1396a(a)(25)) of the Social Security Act.

11 **SEC. 507. PUNITIVE DAMAGES.**

12 (a) IN GENERAL.—Punitive damages may, if other-  
13 wise permitted by applicable State or Federal law, be  
14 awarded against any person in a health care lawsuit only  
15 if it is proven by clear and convincing evidence that such  
16 person acted with malicious intent to injure the claimant,  
17 or that such person deliberately failed to avoid unneces-  
18 sary injury that such person knew the claimant was sub-  
19 stantially certain to suffer. In any health care lawsuit  
20 where no judgment for compensatory damages is rendered  
21 against such person, no punitive damages may be awarded  
22 with respect to the claim in such lawsuit. No demand for  
23 punitive damages shall be included in a health care lawsuit  
24 as initially filed. A court may allow a claimant to file an  
25 amended pleading for punitive damages only upon a mo-

1 tion by the claimant and after a finding by the court, upon  
2 review of supporting and opposing affidavits or after a  
3 hearing, after weighing the evidence, that the claimant has  
4 established by a substantial probability that the claimant  
5 will prevail on the claim for punitive damages. At the re-  
6 quest of any party in a health care lawsuit, the trier of  
7 fact shall consider in a separate proceeding—

8 (1) whether punitive damages are to be award-  
9 ed and the amount of such award; and

10 (2) the amount of punitive damages following a  
11 determination of punitive liability.

12 If a separate proceeding is requested, evidence relevant  
13 only to the claim for punitive damages, as determined by  
14 applicable State law, shall be inadmissible in any pro-  
15 ceeding to determine whether compensatory damages are  
16 to be awarded.

17 (b) DETERMINING AMOUNT OF PUNITIVE DAM-  
18 AGES.—

19 (1) FACTORS CONSIDERED.—In determining  
20 the amount of punitive damages, if awarded, in a  
21 health care lawsuit, the trier of fact shall consider  
22 only the following—

23 (A) the severity of the harm caused by the  
24 conduct of such party;

1 (B) the duration of the conduct or any  
2 concealment of it by such party;

3 (C) the profitability of the conduct to such  
4 party;

5 (D) the number of products sold or med-  
6 ical procedures rendered for compensation, as  
7 the case may be, by such party, of the kind  
8 causing the harm complained of by the claim-  
9 ant;

10 (E) any criminal penalties imposed on such  
11 party, as a result of the conduct complained of  
12 by the claimant; and

13 (F) the amount of any civil fines assessed  
14 against such party as a result of the conduct  
15 complained of by the claimant.

16 (2) MAXIMUM AWARD.—The amount of punitive  
17 damages, if awarded, in a health care lawsuit may  
18 be as much as \$250,000 or as much as two times  
19 the amount of economic damages awarded, which-  
20 ever is greater. The jury shall not be informed of  
21 this limitation.

22 (c) NO PUNITIVE DAMAGES FOR PRODUCTS THAT  
23 COMPLY WITH FDA STANDARDS.—

24 (1) IN GENERAL.—

1 (A) No punitive damages may be awarded  
2 against the manufacturer or distributor of a  
3 medical product, or a supplier of any compo-  
4 nent or raw material of such medical product,  
5 based on a claim that such product caused the  
6 claimant's harm where—

7 (i)(I) such medical product was sub-  
8 ject to premarket approval, clearance, or li-  
9 censure by the Food and Drug Administra-  
10 tion with respect to the safety of the for-  
11 mulation or performance of the aspect of  
12 such medical product which caused the  
13 claimant's harm or the adequacy of the  
14 packaging or labeling of such medical  
15 product; and

16 (II) such medical product was so ap-  
17 proved, cleared, or licensed; or

18 (ii) such medical product is generally  
19 recognized among qualified experts as safe  
20 and effective pursuant to conditions estab-  
21 lished by the Food and Drug Administra-  
22 tion and applicable Food and Drug Admin-  
23 istration regulations, including without  
24 limitation those related to packaging and  
25 labeling, unless the Food and Drug Admin-

1           istration has determined that such medical  
2           product was not manufactured or distrib-  
3           uted in substantial compliance with appli-  
4           cable Food and Drug Administration stat-  
5           utes and regulations.

6           (B) RULE OF CONSTRUCTION.—Subpara-  
7           graph (A) may not be construed as establishing  
8           the obligation of the Food and Drug Adminis-  
9           tration to demonstrate affirmatively that a  
10          manufacturer, distributor, or supplier referred  
11          to in such subparagraph meets any of the con-  
12          ditions described in such subparagraph.

13          (2) LIABILITY OF HEALTH CARE PROVIDERS.—  
14          A health care provider who prescribes, or who dis-  
15          penses pursuant to a prescription, a medical product  
16          approved, licensed, or cleared by the Food and Drug  
17          Administration shall not be named as a party to a  
18          product liability lawsuit involving such product and  
19          shall not be liable to a claimant in a class action  
20          lawsuit against the manufacturer, distributor, or  
21          seller of such product. Nothing in this paragraph  
22          prevents a court from consolidating cases involving  
23          health care providers and cases involving products li-  
24          ability claims against the manufacturer, distributor,  
25          or product seller of such medical product.

1           (3) PACKAGING.—In a health care lawsuit for  
2           harm which is alleged to relate to the adequacy of  
3           the packaging or labeling of a drug which is required  
4           to have tamper-resistant packaging under regula-  
5           tions of the Secretary of Health and Human Serv-  
6           ices (including labeling regulations related to such  
7           packaging), the manufacturer or product seller of  
8           the drug shall not be held liable for punitive dam-  
9           ages unless such packaging or labeling is found by  
10          the trier of fact by clear and convincing evidence to  
11          be substantially out of compliance with such regula-  
12          tions.

13          (4) EXCEPTION.—Paragraph (1) shall not  
14          apply in any health care lawsuit in which—

15                 (A) a person, before or after premarket ap-  
16                 proval, clearance, or licensure of such medical  
17                 product, knowingly misrepresented to or with-  
18                 held from the Food and Drug Administration  
19                 information that is required to be submitted  
20                 under the Federal Food, Drug, and Cosmetic  
21                 Act (21 U.S.C. 301 et seq.) or section 351 of  
22                 the Public Health Service Act (42 U.S.C. 262)  
23                 that is material and is causally related to the  
24                 harm which the claimant allegedly suffered; or

1 (B) a person made an illegal payment to  
2 an official of the Food and Drug Administra-  
3 tion for the purpose of either securing or main-  
4 taining approval, clearance, or licensure of such  
5 medical product.

6 **SEC. 508. AUTHORIZATION OF PAYMENT OF FUTURE DAM-**  
7 **AGES TO CLAIMANTS IN HEALTH CARE LAW-**  
8 **SUITS.**

9 (a) IN GENERAL.—In any health care lawsuit, if an  
10 award of future damages, without reduction to present  
11 value, equaling or exceeding \$50,000 is made against a  
12 party with sufficient insurance or other assets to fund a  
13 periodic payment of such a judgment, the court shall, at  
14 the request of any party, enter a judgment ordering that  
15 the future damages be paid by periodic payments. In any  
16 health care lawsuit, the court may be guided by the Uni-  
17 form Periodic Payment of Judgments Act promulgated by  
18 the National Conference of Commissioners on Uniform  
19 State Laws.

20 (b) APPLICABILITY.—This section applies to all ac-  
21 tions which have not been first set for trial or retrial be-  
22 fore the effective date of this title.

23 **SEC. 509. DEFINITIONS.**

24 In this title:

1           (1) ALTERNATIVE DISPUTE RESOLUTION SYS-  
2           TEM; ADR.—The term “alternative dispute resolution  
3           system” or “ADR” means a system that provides  
4           for the resolution of health care lawsuits in a man-  
5           ner other than through a civil action brought in a  
6           State or Federal court.

7           (2) CLAIMANT.—The term “claimant” means  
8           any person who brings a health care lawsuit, includ-  
9           ing a person who asserts or claims a right to legal  
10          or equitable contribution, indemnity or subrogation,  
11          arising out of a health care liability claim or action,  
12          and any person on whose behalf such a claim is as-  
13          serted or such an action is brought, whether de-  
14          ceased, incompetent, or a minor.

15          (3) COLLATERAL SOURCE BENEFITS.—The  
16          term “collateral source benefits” means any amount  
17          paid or reasonably likely to be paid in the future to  
18          or on behalf of the claimant, or any service, product  
19          or other benefit provided or reasonably likely to be  
20          provided in the future to or on behalf of the claim-  
21          ant, as a result of the injury or wrongful death, pur-  
22          suant to—

23                   (A) any State or Federal health, sickness,  
24                   income-disability, accident, or workers’ com-  
25                   pensation law;

1 (B) any health, sickness, income-disability,  
2 or accident insurance that provides health bene-  
3 fits or income-disability coverage;

4 (C) any contract or agreement of any  
5 group, organization, partnership, or corporation  
6 to provide, pay for, or reimburse the cost of  
7 medical, hospital, dental, or income disability  
8 benefits; and

9 (D) any other publicly or privately funded  
10 program.

11 (4) COMPENSATORY DAMAGES.—The term  
12 “compensatory damages” means objectively  
13 verifiable monetary losses incurred as a result of the  
14 provision of, use of, or payment for (or failure to  
15 provide, use, or pay for) health care services or med-  
16 ical products, such as past and future medical ex-  
17 penses, loss of past and future earnings, cost of ob-  
18 taining domestic services, loss of employment, and  
19 loss of business or employment opportunities, dam-  
20 ages for physical and emotional pain, suffering, in-  
21 convenience, physical impairment, mental anguish,  
22 disfigurement, loss of enjoyment of life, loss of soci-  
23 ety and companionship, loss of consortium (other  
24 than loss of domestic service), hedonic damages, in-  
25 jury to reputation, and all other nonpecuniary losses

1 of any kind or nature. The term “compensatory  
2 damages” includes economic damages and non-  
3 economic damages, as such terms are defined in this  
4 section.

5 (5) CONTINGENT FEE.—The term “contingent  
6 fee” includes all compensation to any person or per-  
7 sons which is payable only if a recovery is effected  
8 on behalf of one or more claimants.

9 (6) ECONOMIC DAMAGES.—The term “economic  
10 damages” means objectively verifiable monetary  
11 losses incurred as a result of the provision of, use  
12 of, or payment for (or failure to provide, use, or pay  
13 for) health care services or medical products, such as  
14 past and future medical expenses, loss of past and  
15 future earnings, cost of obtaining domestic services,  
16 loss of employment, and loss of business or employ-  
17 ment opportunities.

18 (7) HEALTH CARE LAWSUIT.—The term  
19 “health care lawsuit” means any health care liability  
20 claim concerning the provision of health care goods  
21 or services or any medical product affecting inter-  
22 state commerce, or any health care liability action  
23 concerning the provision of health care goods or  
24 services or any medical product affecting interstate  
25 commerce, brought in a State or Federal court or

1       pursuant to an alternative dispute resolution system,  
2       against a health care provider, a health care organi-  
3       zation, or the manufacturer, distributor, supplier,  
4       marketer, promoter, or seller of a medical product,  
5       regardless of the theory of liability on which the  
6       claim is based, or the number of claimants, plain-  
7       tiffs, defendants, or other parties, or the number of  
8       claims or causes of action, in which the claimant al-  
9       leges a health care liability claim. Such term does  
10      not include a claim or action which is based on  
11      criminal liability; which seeks civil fines or penalties  
12      paid to Federal, State, or local government; or which  
13      is grounded in antitrust.

14           (8) HEALTH CARE LIABILITY ACTION.—The  
15      term “health care liability action” means a civil ac-  
16      tion brought in a State or Federal Court or pursu-  
17      ant to an alternative dispute resolution system,  
18      against a health care provider, a health care organi-  
19      zation, or the manufacturer, distributor, supplier,  
20      marketer, promoter, or seller of a medical product,  
21      regardless of the theory of liability on which the  
22      claim is based, or the number of plaintiffs, defend-  
23      ants, or other parties, or the number of causes of ac-  
24      tion, in which the claimant alleges a health care li-  
25      ability claim.

1           (9) HEALTH CARE LIABILITY CLAIM.—The  
2 term “health care liability claim” means a demand  
3 by any person, whether or not pursuant to ADR,  
4 against a health care provider, health care organiza-  
5 tion, or the manufacturer, distributor, supplier, mar-  
6 keter, promoter, or seller of a medical product, in-  
7 cluding, but not limited to, third-party claims, cross-  
8 claims, counter-claims, or contribution claims, which  
9 are based upon the provision of, use of, or payment  
10 for (or the failure to provide, use, or pay for) health  
11 care services or medical products, regardless of the  
12 theory of liability on which the claim is based, or the  
13 number of plaintiffs, defendants, or other parties, or  
14 the number of causes of action.

15           (10) HEALTH CARE ORGANIZATION.—The term  
16 “health care organization” means any person or en-  
17 tity which is obligated to provide or pay for health  
18 benefits under any health plan, including any person  
19 or entity acting under a contract or arrangement  
20 with a health care organization to provide or admin-  
21 ister any health benefit.

22           (11) HEALTH CARE PROVIDER.—The term  
23 “health care provider” means any person or entity  
24 required by State or Federal laws or regulations to  
25 be licensed, registered, or certified to provide health

1 care services, and being either so licensed, reg-  
2 istered, or certified, or exempted from such require-  
3 ment by other statute or regulation.

4 (12) HEALTH CARE GOODS OR SERVICES.—The  
5 term “health care goods or services” means any  
6 goods or services provided by a health care organiza-  
7 tion, provider, or by any individual working under  
8 the supervision of a health care provider, that relates  
9 to the diagnosis, prevention, or treatment of any  
10 human disease or impairment, or the assessment or  
11 care of the health of human beings.

12 (13) MALICIOUS INTENT TO INJURE.—The  
13 term “malicious intent to injure” means inten-  
14 tionally causing or attempting to cause physical in-  
15 jury other than providing health care goods or serv-  
16 ices.

17 (14) MEDICAL PRODUCT.—The term “medical  
18 product” means a drug, device, or biological product  
19 intended for humans, and the terms “drug”, “de-  
20 vice”, and “biological product” have the meanings  
21 given such terms in sections 201(g)(1) and 201(h)  
22 of the Federal Food, Drug and Cosmetic Act (21  
23 U.S.C. 321) and section 351(a) of the Public Health  
24 Service Act (42 U.S.C. 262(a)), respectively, includ-

1       ing any component or raw material used therein, but  
2       excluding health care services.

3           (15) NONECONOMIC DAMAGES.—The term  
4       “noneconomic damages” means damages for phys-  
5       ical and emotional pain, suffering, inconvenience,  
6       physical impairment, mental anguish, disfigurement,  
7       loss of enjoyment of life, loss of society and compan-  
8       ionship, loss of consortium (other than loss of do-  
9       mestic service), hedonic damages, injury to reputa-  
10      tion, and all other nonpecuniary losses of any kind  
11      or nature.

12          (16) PUNITIVE DAMAGES.—The term “punitive  
13      damages” means damages awarded, for the purpose  
14      of punishment or deterrence, and not solely for com-  
15      pensatory purposes, against a health care provider,  
16      health care organization, or a manufacturer, dis-  
17      tributor, or supplier of a medical product. Punitive  
18      damages are neither economic nor noneconomic  
19      damages.

20          (17) RECOVERY.—The term “recovery” means  
21      the net sum recovered after deducting any disburse-  
22      ments or costs incurred in connection with prosecu-  
23      tion or settlement of the claim, including all costs  
24      paid or advanced by any person. Costs of health care  
25      incurred by the plaintiff and the attorneys’ office

1 overhead costs or charges for legal services are not  
2 deductible disbursements or costs for such purpose.

3 (18) STATE.—The term “State” means each of  
4 the several States, the District of Columbia, the  
5 Commonwealth of Puerto Rico, the Virgin Islands,  
6 Guam, American Samoa, the Northern Mariana Is-  
7 lands, the Trust Territory of the Pacific Islands, and  
8 any other territory or possession of the United  
9 States, or any political subdivision thereof.

10 **SEC. 510. EFFECT ON OTHER LAWS.**

11 (a) VACCINE INJURY.—

12 (1) To the extent that title XXI of the Public  
13 Health Service Act establishes a Federal rule of law  
14 applicable to a civil action brought for a vaccine-re-  
15 lated injury or death—

16 (A) this title does not affect the application  
17 of the rule of law to such an action; and

18 (B) any rule of law prescribed by this title  
19 in conflict with a rule of law of such title XXI  
20 shall not apply to such action.

21 (2) If there is an aspect of a civil action  
22 brought for a vaccine-related injury or death to  
23 which a Federal rule of law under title XXI of the  
24 Public Health Service Act does not apply, then this  
25 title or otherwise applicable law (as determined

1 under this title) will apply to such aspect of such ac-  
2 tion.

3 (b) OTHER FEDERAL LAW.—Except as provided in  
4 this section, nothing in this title shall be deemed to affect  
5 any defense available to a defendant in a health care law-  
6 suit or action under any other provision of Federal law.

7 **SEC. 511. STATE FLEXIBILITY AND PROTECTION OF**  
8 **STATES' RIGHTS.**

9 (a) HEALTH CARE LAWSUITS.—The provisions gov-  
10 erning health care lawsuits set forth in this title preempt,  
11 subject to subsections (b) and (c), State law to the extent  
12 that State law prevents the application of any provisions  
13 of law established by or under this title. The provisions  
14 governing health care lawsuits set forth in this title super-  
15 sede chapter 171 of title 28, United States Code, to the  
16 extent that such chapter—

17 (1) provides for a greater amount of damages  
18 or contingent fees, a longer period in which a health  
19 care lawsuit may be commenced, or a reduced appli-  
20 cability or scope of periodic payment of future dam-  
21 ages, than provided in this title; or

22 (2) prohibits the introduction of evidence re-  
23 garding collateral source benefits, or mandates or  
24 permits subrogation or a lien on collateral source  
25 benefits.

1 (b) PROTECTION OF STATES' RIGHTS AND OTHER  
2 LAWS.—(1) Any issue that is not governed by any provi-  
3 sion of law established by or under this title (including  
4 State standards of gross negligence) shall be governed by  
5 otherwise applicable State or Federal law.

6 (2) This title shall not preempt or supersede any  
7 State or Federal law that imposes greater procedural or  
8 substantive protections for health care providers and  
9 health care organizations from liability, loss, or damages  
10 than those provided by this title or create a cause of ac-  
11 tion.

12 (c) STATE FLEXIBILITY.—No provision of this title  
13 shall be construed to preempt—

14 (1) any State law (whether effective before, on,  
15 or after the date of the enactment of this title) that  
16 specifies a particular monetary amount of compen-  
17 satory or punitive damages (or the total amount of  
18 damages) that may be awarded in a health care law-  
19 suit, regardless of whether such monetary amount is  
20 greater or lesser than is provided for under this title,  
21 notwithstanding section 404(a); or

22 (2) any defense available to a party in a health  
23 care lawsuit under any other provision of State or  
24 Federal law.

1 **SEC. 512. APPLICABILITY; EFFECTIVE DATE.**

2 The previous provisions of this title shall apply to any  
3 health care lawsuit brought in a Federal or State court,  
4 or subject to an alternative dispute resolution system, that  
5 is initiated on or after the date of the enactment of this  
6 title, except that any health care lawsuit arising from an  
7 injury occurring prior to the date of the enactment of this  
8 title shall be governed by the applicable statute of limita-  
9 tions provisions in effect at the time the injury occurred.

10 **SEC. 513. SENSE OF CONGRESS.**

11 It is the sense of Congress that a health insurer  
12 should be liable for damages for harm caused when it  
13 makes a decision as to what care is medically necessary  
14 and appropriate.

15 **SEC. 514. STATE GRANTS TO CREATE ADMINISTRATIVE**  
16 **HEALTH CARE TRIBUNALS.**

17 Part P of title III of the Public Health Service Act  
18 (42 U.S.C. 280g et seq.) is amended by adding at the end  
19 the following:

20 **“SEC. 399T. STATE GRANTS TO CREATE ADMINISTRATIVE**  
21 **HEALTH CARE TRIBUNALS.**

22 “(a) IN GENERAL.—The Secretary may award grants  
23 to States for the development, implementation, and eval-  
24 uation of administrative health care tribunals that comply  
25 with this section, for the resolution of disputes concerning  
26 injuries allegedly caused by health care providers.

1           “(b) CONDITIONS FOR DEMONSTRATION GRANTS.—

2 To be eligible to receive a grant under this section, a State  
3 shall submit to the Secretary an application at such time,  
4 in such manner, and containing such information as may  
5 be required by the Secretary. A grant shall be awarded  
6 under this section on such terms and conditions as the  
7 Secretary determines appropriate.

8           “(c) REPRESENTATION BY COUNSEL.—A State that  
9 receives a grant under this section may not preclude any  
10 party to a dispute before an administrative health care tri-  
11 bunal operated under such grant from obtaining legal rep-  
12 resentation during any review by the expert panel under  
13 subsection (d), the administrative health care tribunal  
14 under subsection (e), or a State court under subsection  
15 (f).

16           “(d) EXPERT PANEL REVIEW AND EARLY OFFER  
17 GUIDELINES.—

18           “(1) IN GENERAL.—Prior to the submission of  
19 any dispute concerning injuries allegedly caused by  
20 health care providers to an administrative health  
21 care tribunal under this section, such allegations  
22 shall first be reviewed by an expert panel.

23           “(2) COMPOSITION.—

24           “(A) IN GENERAL.—The members of each  
25 expert panel under this subsection shall be ap-

1 pointed by the head of the State agency respon-  
2 sible for health. Each expert panel shall be  
3 composed of no fewer than 3 members and not  
4 more than 7 members. At least one-half of such  
5 members shall be medical experts (either physi-  
6 cians or health care professionals).

7 “(B) LICENSURE AND EXPERTISE.—Each  
8 physician or health care professional appointed  
9 to an expert panel under subparagraph (A)  
10 shall—

11 “(i) be appropriately credentialed or  
12 licensed in 1 or more States to deliver  
13 health care services; and

14 “(ii) typically treat the condition,  
15 make the diagnosis, or provide the type of  
16 treatment that is under review.

17 “(C) INDEPENDENCE.—

18 “(i) IN GENERAL.—Subject to clause  
19 (ii), each individual appointed to an expert  
20 panel under this paragraph shall—

21 “(I) not have a material familial,  
22 financial, or professional relationship  
23 with a party involved in the dispute  
24 reviewed by the panel; and

1                   “(II) not otherwise have a con-  
2                   flict of interest with such a party.

3                   “(ii) EXCEPTION.—Nothing in clause  
4                   (i) shall be construed to prohibit an indi-  
5                   vidual who has staff privileges at an insti-  
6                   tution where the treatment involved in the  
7                   dispute was provided from serving as a  
8                   member of an expert panel merely on the  
9                   basis of such affiliation, if the affiliation is  
10                  disclosed to the parties and neither party  
11                  objects.

12                  “(D) PRACTICING HEALTH CARE PROFES-  
13                  SIONAL IN SAME FIELD.—

14                  “(i) IN GENERAL.—In a dispute be-  
15                  fore an expert panel that involves treat-  
16                  ment, or the provision of items or serv-  
17                  ices—

18                  “(I) by a physician, the medical  
19                  experts on the expert panel shall be  
20                  practicing physicians (allopathic or os-  
21                  teopathic) of the same or similar spe-  
22                  cialty as a physician who typically  
23                  treats the condition, makes the diag-  
24                  nosis, or provides the type of treat-  
25                  ment under review; or

1                   “(II) by a health care profes-  
2                   sional other than a physician, at least  
3                   two medical experts on the expert  
4                   panel shall be practicing physicians  
5                   (allopathic or osteopathic) of the same  
6                   or similar specialty as the health care  
7                   professional who typically treats the  
8                   condition, makes the diagnosis, or  
9                   provides the type of treatment under  
10                  review, and, if determined appropriate  
11                  by the State agency, an additional  
12                  medical expert shall be a practicing  
13                  health care professional (other than  
14                  such a physician) of such a same or  
15                  similar specialty.

16                  “(ii) PRACTICING DEFINED.—In this  
17                  paragraph, the term ‘practicing’ means,  
18                  with respect to an individual who is a phy-  
19                  sician or other health care professional,  
20                  that the individual provides health care  
21                  services to individual patients on average  
22                  at least 2 days a week.

23                  “(E) PEDIATRIC EXPERTISE.—In the case  
24                  of dispute relating to a child, at least 1 medical

1 expert on the expert panel shall have expertise  
2 described in subparagraph (D)(i) in pediatrics.

3 “(3) DETERMINATION.—After a review under  
4 paragraph (1), an expert panel shall make a deter-  
5 mination as to the liability of the parties involved  
6 and compensation.

7 “(4) ACCEPTANCE.—If the parties to a dispute  
8 before an expert panel under this subsection accept  
9 the determination of the expert panel concerning li-  
10 ability and compensation, such compensation shall  
11 be paid to the claimant and the claimant shall agree  
12 to forgo any further action against the health care  
13 providers involved.

14 “(5) FAILURE TO ACCEPT.—If any party de-  
15 cides not to accept the expert panel’s determination,  
16 the matter shall be referred to an administrative  
17 health care tribunal created pursuant to this section.

18 “(e) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

19 “(1) IN GENERAL.—Upon the failure of any  
20 party to accept the determination of an expert panel  
21 under subsection (d), the parties shall have the right  
22 to request a hearing concerning the liability or com-  
23 pensation involved by an administrative health care  
24 tribunal established by the State involved.

1           “(2) REQUIREMENTS.—In establishing an ad-  
2           ministrative health care tribunal under this section,  
3           a State shall—

4                   “(A) ensure that such tribunals are pre-  
5                   sided over by special judges with health care ex-  
6                   pertise;

7                   “(B) provide authority to such judges to  
8                   make binding rulings, rendered in written deci-  
9                   sions, on standards of care, causation, com-  
10                  pensation, and related issues with reliance on  
11                  independent expert witnesses commissioned by  
12                  the tribunal;

13                  “(C) establish gross negligence as the legal  
14                  standard for the tribunal;

15                  “(D) allow the admission into evidence of  
16                  the recommendation made by the expert panel  
17                  under subsection (d); and

18                  “(E) provide for an appeals process to  
19                  allow for review of decisions by State courts.

20           “(f) REVIEW BY STATE COURT AFTER EXHAUSTION  
21           OF ADMINISTRATIVE REMEDIES.—

22                   “(1) RIGHT TO FILE.—If any party to a dispute  
23                   before a health care tribunal under subsection (e) is  
24                   not satisfied with the determinations of the tribunal,

1 the party shall have the right to file their claim in  
2 a State court of competent jurisdiction.

3 “(2) FORFEIT OF AWARDS.—Any party filing  
4 an action in a State court in accordance with para-  
5 graph (1) shall forfeit any compensation award  
6 made under subsection (e).

7 “(3) ADMISSIBILITY.—The determinations of  
8 the expert panel and the administrative health care  
9 tribunal pursuant to subsections (d) and (e) with re-  
10 spect to a State court proceeding under paragraph  
11 (1) shall be admissible into evidence in any such  
12 State court proceeding.

13 “(g) DEFINITION.—In this section, the term ‘health  
14 care provider’ has the meaning given such term for pur-  
15 poses of part A of title VII.

16 “(h) AUTHORIZATION OF APPROPRIATIONS.—There  
17 are authorized to be appropriated for any fiscal year such  
18 sums as may be necessary for purposes of making grants  
19 to States under this section.”.

20 **SEC. 515. AFFIRMATIVE DEFENSE BASED ON COMPLIANCE**  
21 **WITH BEST PRACTICE GUIDELINES.**

22 (a) SELECTION AND ISSUANCE OF BEST PRACTICES  
23 GUIDELINES.—

24 (1) IN GENERAL.—The Secretary of Health and  
25 Human Services (in this section referred to as the

1 “Secretary”) shall provide for the selection and  
2 issuance of best practice guidelines (each in this sub-  
3 section referred to as a “guideline”) in accordance  
4 with paragraphs (2) and (3).

5 (2) DEVELOPMENT PROCESS.—Not later than  
6 90 days after the date of the enactment of this Act,  
7 the Secretary shall enter into a contract with a  
8 qualified physician consensus-building organization  
9 (such as the Physician Consortium for Performance  
10 Improvement), in concert and agreement with physi-  
11 cian specialty organizations, to develop guidelines for  
12 treatment of medical conditions for application  
13 under subsection (b). Under the contract, the orga-  
14 nization shall take into consideration any endorsed  
15 performance-based quality measures described in  
16 section 802. Under the contract and not later than  
17 18 months after the date of the enactment of this  
18 Act, the organization shall submit best practice  
19 guidelines for issuance as guidelines under para-  
20 graph (3).

21 (3) ISSUANCE.—

22 (A) IN GENERAL.—Not later than 2 years  
23 after the date of the enactment of this Act, the  
24 Secretary shall issue, by regulation, after notice  
25 and opportunity for public comment, guidelines

1           that have been recommended under paragraph  
2           (2) for application under subsection (b).

3           (B) LIMITATION.—The Secretary may not  
4           issue guidelines unless they have been approved  
5           or endorsed by qualified physician consensus-  
6           building organization involved and physician  
7           specialty organizations.

8           (C) DISSEMINATION.—The Secretary shall  
9           broadly disseminate the guidelines so issued.

10          (b) LIMITATION ON DAMAGES.—

11           (1) LIMITATION ON NONECONOMIC DAMAGES.—  
12           In any health care lawsuit, no noneconomic damages  
13           may awarded with respect to treatment that is with-  
14           in a guideline issued under subsection (a).

15           (2) LIMITATION ON PUNITIVE DAMAGES.—In  
16           any health care lawsuit, no punitive damages may be  
17           awarded against a health care practitioner based on  
18           a claim that such treatment caused the claimant  
19           harm if—

20           (A) such treatment was subject to the  
21           quality review by a qualified physician con-  
22           sensus-building organization;

23           (B) such treatment was approved in a  
24           guideline that underwent full review by such or-  
25           ganization, public comment, approval by the

1 Secretary, and dissemination as described in  
2 subparagraph (a); and

3 (C) such medical treatment is generally  
4 recognized among qualified experts (including  
5 medical providers and relevant physician spe-  
6 cialty organizations) as safe, effective, and ap-  
7 propriate.

8 (c) USE.—

9 (1) INTRODUCTION AS EVIDENCE.—Guidelines  
10 under subsection (a) may not be introduced as evi-  
11 dence of negligence or deviation in the standard of  
12 care in any civil action unless they have previously  
13 been introduced by the defendant.

14 (2) NO PRESUMPTION OF NEGLIGENCE.—There  
15 would be no presumption of negligence if a partici-  
16 pating physician does not adhere to such guidelines.

17 (d) CONSTRUCTION.—Nothing in this section shall be  
18 construed as preventing a State from—

19 (1) replacing their current medical malpractice  
20 rules with rules that rely, as a defense, upon a  
21 health care provider's compliance with a guideline  
22 issued under subsection (a); or

23 (2) applying additional guidelines or safe-har-  
24 bors that are in addition to, but not in lieu of, the  
25 guidelines issued under subsection (a).

1 **SEC. 516. 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           such term in section 1861(q) of the Social Se-  
2           curity Act (42 U.S.C. 1395x(q)).”.

3           (b) **EFFECTIVE DATE.**—The amendments made by  
4 this section shall apply to debts arising from services per-  
5 formed in taxable years beginning after the date of the  
6 enactment of this Act.

## 7           **TITLE VI—WELLNESS AND** 8           **PREVENTION**

### 9           **SEC. 601. PROVIDING FINANCIAL INCENTIVES FOR TREAT-** 10           **MENT COMPLIANCE.**

11           (a) **ERISA LIMITATION ON EXCEPTION FOR**  
12 **WELLNESS PROGRAMS UNDER HIPAA DISCRIMINATION**  
13 **RULES.**—Section 702(b)(2) of the Employee Retirement  
14 Income Security Act of 1974 (29 U.S.C. 1182(b)(2)) is  
15 amended by adding after and below subparagraph (B) the  
16 following:

17           “**In applying subparagraph (B), a group health plan**  
18           **(or a health insurance issuer with respect to health**  
19           **insurance coverage) may vary premiums and cost-**  
20           **sharing by up to 50 percent of the value of the bene-**  
21           **fits under the plan (or coverage) based on participa-**  
22           **tion (or lack of participation) in a standards-based**  
23           **wellness program.”.**

1 (b) EFFECTIVE DATE.—The amendment 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 website or web portal  
20 accessible by the requesting plan, plan sponsor,  
21 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 this, but not in lieu of.

17          “(f) DEFINITIONS.—In this section:

18           “(1) The terms ‘employer’, ‘plan administrator’,  
19      and ‘plan sponsor’ have the meanings given such  
20      terms in section 3 of the Employee Retirement In-  
21      come Security Act of 1974.

22           “(2) The term ‘HIPAA privacy regulations’ has  
23      the meaning given such term in section 1180(b)(3)  
24      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 proposal shall be in concert and agreement with the Physi-  
2 cian Consortium for Performance Improvement and shall  
3 only utilize measures agreed upon by each physician spe-  
4 cialty organization.

5 **TITLE IX—STATE**  
6 **TRANSPARENCY PLAN PORTAL**

7 **SEC. 901. PROVIDING INFORMATION ON HEALTH COV-**  
8 **ERAGE OPTIONS AND HEALTH CARE PRO-**  
9 **VIDERS.**

10 (a) STATE-BASED PORTAL.—A State (by itself or  
11 jointly with other States) may contract with a private enti-  
12 ty to establish a Health Plan and Provider Portal website  
13 (referred to in this section as a “plan portal”) for the pur-  
14 poses of providing standardized information—

15 (1) on health insurance plans that have been  
16 certified to be available for purchase in that State;  
17 and

18 (2) on price and quality information on health  
19 care providers (including physicians, hospitals, and  
20 other health care institutions).

21 (b) PILOT PROGRAM.—

22 (1) IN GENERAL.—Not later than 90 days after  
23 the date of the enactment of this Act the Secretary  
24 of Health and Human Services shall work with  
25 States to establish no later than 2011, consistent

1 with this title, a website that will serve as a pilot  
2 program for a national portal for information struc-  
3 tured in a manner so individuals may directly link  
4 to the State plan portal for the State in which they  
5 reside.

6 (2) CONTRACTS WITH STATE.—The Secretary  
7 shall enter into contracts with States, in a number  
8 and distribution determined by the Secretary, to de-  
9 velop State plan portals that follow the applicable  
10 standards and regulations under this section.

11 (3) COMMON STANDARDS FOR PLAN POR-  
12 TALS.—

13 (A) IN GENERAL.—In connection with such  
14 website, the Secretary shall establish standards  
15 for interoperability and consistency for State  
16 plan portals so that individuals can access and  
17 view information in a similar manner on plan  
18 portals of different States. Such standards shall  
19 include standard definitions for health insur-  
20 ance plan benefits so that individuals can accu-  
21 rately compare health insurance plans within  
22 such portals and standards for the inclusion of  
23 information described in subsection (c).

24 (B) CONSULTATION.—The Secretary shall  
25 consult with a group consisting of a balanced

1 representation of the critical stakeholders (in-  
2 cluding States, health insurance issuers, the  
3 National Association of Insurance Commis-  
4 sioners, qualified health care provider-based en-  
5 tities (including physicians, hospitals, and other  
6 health care institutions), and a standards devel-  
7 opment organization) to develop such stand-  
8 ards.

9 (C) ISSUANCE.—

10 (i) IN GENERAL.—Not later than 6  
11 months after the date of the enactment of  
12 this Act, the Secretary shall issue, by regu-  
13 lation, after notice and opportunity for  
14 public comment, standards that are con-  
15 sistent with the recommendations made by  
16 the group under subparagraph (B).

17 (ii) DISSEMINATION.—The Secretary  
18 shall broadly disseminate the standards so  
19 issued.

20 (D) REVIEW.—One year after the date of  
21 establishment of the pilot program under this  
22 subsection, the Secretary, in consultation with  
23 stakeholder group described in subparagraph  
24 (B), shall review the standards established and

1           make such changes in such standards as may  
2           be appropriate.

3           (4) AUTHORIZATION OF APPROPRIATIONS.—

4           There are authorized to be appropriated to the Sec-  
5           retary such amounts as may be necessary for—

6                   (A) the development and operation of the  
7                   national website under this subsection; and

8                   (B) contracts with States under paragraph  
9                   (2) to assist in the development and initial op-  
10                  eration of plan portals in accordance with  
11                  standards established under paragraph (3) and  
12                  other applicable provisions of this section.

13          (c) INFORMATION IN PLAN PORTALS.—The stand-  
14          ards for plan portals under subsection (b)(3) shall include  
15          the following:

16                  (1) HEALTH INSURANCE INFORMATION.—Each  
17                  plan portal shall meet the following requirements  
18                  with respect to information on health insurance  
19                  plans:

20                          (A) The plan portal shall present complete  
21                          information on the costs and benefits of health  
22                          insurance plans (including information on  
23                          monthly premium, copayments, deductibles, and  
24                          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 website 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 website described in section  
11 802 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 **TITLE X—PHYSICIAN PAYMENT**

### 19 **REFORM**

#### 20 **SEC. 1001. SUSTAINABLE GROWTH RATE REFORM.**

21 (a) TRANSITIONAL UPDATE FOR 2010.—Section  
22 1848(d) of the Social Security Act (42 U.S.C. 1395w-  
23 4(d)) is amended by adding at the end the following new  
24 paragraph:

1           “(10) UPDATE FOR 2010.—The update to the  
2           single conversion factor established in paragraph  
3           (1)(C) for 2010 shall be the percentage increase in  
4           the MEI (as defined in section 1842(i)(3)) for that  
5           year.”.

6           (b) REBASING SGR USING 2009; LIMITATION ON  
7           CUMULATIVE ADJUSTMENT PERIOD.—Section 1848(d)(4)  
8           of such Act (42 U.S.C. 1395w-4(d)(4)) is amended—

9           (1) in subparagraph (B), by striking “subpara-  
10           graph (D)” and inserting “subparagraphs (D) and  
11           (G)”; and

12           (2) by adding at the end the following new sub-  
13           paragraph:

14                   “(G) REBASING USING 2009 FOR FUTURE  
15                   UPDATE ADJUSTMENTS.—In determining the  
16                   update adjustment factor under subparagraph  
17                   (B) for 2011 and subsequent years—

18                           “(i) the allowed expenditures for 2009  
19                           shall be equal to the amount of the actual  
20                           expenditures for physicians’ services during  
21                           2009; and

22                           “(ii) the reference in subparagraph  
23                           (B)(ii)(I) to ‘April 1, 1996’ shall be treat-  
24                           ed as a reference to ‘January 1, 2009 (or,

1 if later, the first day of the fifth year be-  
2 fore the year involved)’.”.

3 (c) LIMITATION ON PHYSICIANS’ SERVICES IN-  
4 CLUDED IN TARGET GROWTH RATE COMPUTATION TO  
5 SERVICES COVERED UNDER PHYSICIAN FEE SCHED-  
6 ULE.—Effective for services furnished on or after January  
7 1, 2009, section 1848(f)(4)(A) of such Act is amended  
8 striking “(such as clinical” and all that follows through  
9 “in a physician’s office” and inserting “for which payment  
10 under this part is made under the fee schedule under this  
11 section, for services for practitioners described in section  
12 1842(b)(18)(C) on a basis related to such fee schedule,  
13 or for services described in section 1861(p) (other than  
14 such services when furnished in the facility of a provider  
15 of services)’”.

16 (d) ESTABLISHMENT OF SEPARATE TARGET  
17 GROWTH RATES FOR CATEGORIES OF SERVICES.—

18 (1) ESTABLISHMENT OF SERVICE CAT-  
19 EGORIES.—Subsection (j) of section 1848 of the So-  
20 cial Security Act (42 U.S.C. 1395w-4) is amended  
21 by adding at the end the following new paragraph:

22 “(5) SERVICE CATEGORIES.—For services fur-  
23 nished on or after January 1, 2009, each of the fol-  
24 lowing categories of physicians’ services (as defined

1 in paragraph (3)) shall be treated as a separate  
2 ‘service category’:

3 “(A) Evaluation and management services  
4 that are procedure codes (for services covered  
5 under this title) for—

6 “(i) services in the category des-  
7 igned Evaluation and Management in the  
8 Health Care Common Procedure Coding  
9 System (established by the Secretary under  
10 subsection (c)(5) as of December 31, 2009,  
11 and as subsequently modified by the Sec-  
12 retary); and

13 “(ii) preventive services (as defined in  
14 section 1861(iii)) for which payment is  
15 made under this section.

16 “(B) All other services not described in  
17 subparagraph (A).

18 Service categories established under this paragraph  
19 shall apply without regard to the specialty of the  
20 physician furnishing the service.”.

21 (2) ESTABLISHMENT OF SEPARATE CONVER-  
22 SION FACTORS FOR EACH SERVICE CATEGORY.—  
23 Subsection (d)(1) of section 1848 of the Social Secu-  
24 rity Act (42 U.S.C. 1395w-4) is amended—

25 (A) in subparagraph (A)—

1 (i) by designating the sentence begin-  
2 ning “The conversion factor” as clause (i)  
3 with the heading “APPLICATION OF SIN-  
4 GLE CONVERSION FACTOR.—” and with  
5 appropriate indentation;

6 (ii) by striking “The conversion fac-  
7 tor” and inserting “Subject to clause (ii),  
8 the conversion factor”; and

9 (iii) by adding at the end the fol-  
10 lowing new clause:

11 “(ii) APPLICATION OF MULTIPLE CON-  
12 VERSION FACTORS BEGINNING WITH  
13 2011.—

14 “(I) IN GENERAL.—In applying  
15 clause (i) for years beginning with  
16 2011, separate conversion factors  
17 shall be established for each service  
18 category of physicians’ services (as de-  
19 fined in subsection (j)(5)) and any  
20 reference in this section to a conver-  
21 sion factor for such years shall be  
22 deemed to be a reference to the con-  
23 version factor for each of such cat-  
24 egories.

1                   “(II) INITIAL CONVERSION FAC-  
2                   TORS.—Such factors for 2011 shall be  
3                   based upon the single conversion fac-  
4                   tor for the previous year multiplied by  
5                   the update established under para-  
6                   graph (11) for such category for  
7                   2011.

8                   “(III) UPDATING OF CONVER-  
9                   SION FACTORS.—Such factor for a  
10                  service category for a subsequent year  
11                  shall be based upon the conversion  
12                  factor for such category for the pre-  
13                  vious year and adjusted by the update  
14                  established for such category under  
15                  paragraph (11) for the year in-  
16                  volved.”; and

17                  (B) in subparagraph (D), by striking  
18                  “other physicians’ services” and inserting “for  
19                  physicians’ services described in the service cat-  
20                  egory described in subsection (j)(5)(B)”.

21                  (3) ESTABLISHING UPDATES FOR CONVERSION  
22                  FACTORS FOR SERVICE CATEGORIES.—Section  
23                  1848(d) of the Social Security Act (42 U.S.C.  
24                  1395w-4(d)), as amended by subsection (a), is  
25                  amended—

1 (A) in paragraph (4)(C)(iii), by striking  
2 “The allowed” and inserting “Subject to para-  
3 graph (11)(B), the allowed”; and

4 (B) by adding at the end the following new  
5 paragraph:

6 “(11) UPDATES FOR SERVICE CATEGORIES BE-  
7 GINNING WITH 2011.—

8 “(A) IN GENERAL.—In applying paragraph  
9 (4) for a year beginning with 2011, the fol-  
10 lowing rules apply:

11 “(i) APPLICATION OF SEPARATE UP-  
12 DATE ADJUSTMENTS FOR EACH SERVICE  
13 CATEGORY.—Pursuant to paragraph  
14 (1)(A)(ii)(I), the update shall be made to  
15 the conversion factor for each service cat-  
16 egory (as defined in subsection (j)(5))  
17 based upon an update adjustment factor  
18 for the respective category and year and  
19 the update adjustment factor shall be com-  
20 puted, for a year, separately for each serv-  
21 ice category.

22 “(ii) COMPUTATION OF ALLOWED AND  
23 ACTUAL EXPENDITURES BASED ON SERV-  
24 ICE CATEGORIES.—In computing the prior  
25 year adjustment component and the cumu-

1           relative adjustment component under clauses  
2           (i) and (ii) of paragraph (4)(B), the fol-  
3           lowing rules apply:

4                   “(I) APPLICATION BASED ON  
5                   SERVICE CATEGORIES.—The allowed  
6                   expenditures and actual expenditures  
7                   shall be the allowed and actual ex-  
8                   penditures for the service category, as  
9                   determined under subparagraph (B).

10                   “(II) APPLICATION OF CATEGORY  
11                   SPECIFIC TARGET GROWTH RATE.—  
12                   The growth rate applied under clause  
13                   (ii)(II) of such paragraph shall be the  
14                   target growth rate for the service cat-  
15                   egory involved under subsection (f)(5).

16                   “(B) DETERMINATION OF ALLOWED EX-  
17                   PENDITURES.—In applying paragraph (4) for a  
18                   year beginning with 2010, notwithstanding sub-  
19                   paragraph (C)(iii) of such paragraph, the al-  
20                   lowed expenditures for a service category for a  
21                   year is an amount computed by the Secretary  
22                   as follows:

23                   “(i) FOR 2010.—For 2010:

24                           “(I) TOTAL 2009 ACTUAL EX-  
25                           PENDITURES FOR ALL SERVICES IN-

1 CLUDED IN SGR COMPUTATION FOR  
2 EACH SERVICE CATEGORY.—Compute  
3 total actual expenditures for physi-  
4 cians' services (as defined in sub-  
5 section (f)(4)(A)) for 2009 for each  
6 service category.

7 “(II) INCREASE BY GROWTH  
8 RATE TO OBTAIN 2010 ALLOWED EX-  
9 PENDITURES FOR SERVICE CAT-  
10 EGORY.—Compute allowed expendi-  
11 tures for the service category for 2010  
12 by increasing the allowed expenditures  
13 for the service category for 2009 com-  
14 puted under subclause (I) by the tar-  
15 get growth rate for such service cat-  
16 egory under subsection (f) for 2010.

17 “(ii) FOR SUBSEQUENT YEARS.—For  
18 a subsequent year, take the amount of al-  
19 lowed expenditures for such category for  
20 the preceding year (under clause (i) or this  
21 clause) and increase it by the target  
22 growth rate determined under subsection  
23 (f) for such category and year.”.

24 (4) APPLICATION OF SEPARATE TARGET  
25 GROWTH RATES FOR EACH CATEGORY.—

1           (A) IN GENERAL.—Section 1848(f) of the  
2           Social Security Act (42 U.S.C. 1395w-4(f)) is  
3           amended by adding at the end the following  
4           new paragraph:

5           “(5) APPLICATION OF SEPARATE TARGET  
6           GROWTH RATES FOR EACH SERVICE CATEGORY BE-  
7           GINNING WITH 2010.—The target growth rate for a  
8           year beginning with 2010 shall be computed and ap-  
9           plied separately under this subsection for each serv-  
10          ice category (as defined in subsection (j)(5)) and  
11          shall be computed using the same method for com-  
12          puting the target growth rate except that the factor  
13          described in paragraph (2)(C) for—

14                 “(A) the service category described in sub-  
15                 section (j)(5)(A) shall be increased by 0.02; and

16                 “(B) the service category described in sub-  
17                 section (j)(5)(B) shall be increased by 0.01.”.

18           (B) USE OF TARGET GROWTH RATES.—  
19           Section 1848 of such Act is further amended—  
20                 (i) in subsection (d)—

21                         (I) in paragraph (1)(E)(ii), by in-  
22                         serting “or target” after “sustain-  
23                         able”; and

1 (II) in paragraph (4)(B)(ii)(II),  
2 by inserting “or target” after “sus-  
3 tainable”; and

4 (ii) in the heading of subsection (f),  
5 by inserting “AND TARGET GROWTH  
6 RATE” after “SUSTAINABLE GROWTH  
7 RATE”;

8 (iii) in subsection (f)(1)—

9 (I) by striking “and” at the end  
10 of subparagraph (A);

11 (II) in subparagraph (B), by in-  
12 serting “before 2010” after “each  
13 succeeding year” and by striking the  
14 period at the end and inserting “;  
15 and”;

16 (III) by adding at the end the  
17 following new subparagraph:

18 “(C) November 1 of each succeeding year  
19 the target growth rate for such succeeding year  
20 and each of the 2 preceding years.”; and

21 (iv) in subsection (f)(2), in the matter  
22 before subparagraph (A), by inserting after  
23 “beginning with 2000” the following: “and  
24 ending with 2009”.

1           **TITLE XI—INCENTIVES TO**  
2 **REDUCE PHYSICIAN SHORTAGES**  
3 **Subtitle A—Federally Supported**  
4 **Student Loan Funds for Medical**  
5 **Students**

6 **SEC. 1101. FEDERALLY SUPPORTED STUDENT LOAN FUNDS**  
7 **FOR MEDICAL STUDENTS.**

8           (a) PRIMARY HEALTH CARE MEDICAL STUDENTS.—  
9 Subpart II of part A of the Public Health Service Act (42  
10 U.S.C. 292q et seq.) is amended—

11                 (1) by redesignating section 735 as section 729;  
12                 and

13                 (2) in subsection (f) of section 729 (as so reded-  
14                 ignated), by striking “is authorized to be appro-  
15                 priated to be appropriated \$10,000,000 for each of  
16                 the fiscal years 1994 through 1996” and inserting  
17                 “are authorized to be appropriated such sums as  
18                 may be necessary for fiscal year 2010 and each fis-  
19                 cal year thereafter”.

20           (b) OTHER MEDICAL STUDENTS.—Part A of title VII  
21 of the Public Health Service Act (42 U.S.C. 292 et seq.)  
22 is amended by adding at the end the following:

1       **“Subpart III—Federally Supported Student Loan**

2                       **Funds for Certain Medical Students**

3       **“SEC. 730. SCHOOL LOAN FUNDS FOR CERTAIN MEDICAL**  
4                       **STUDENTS.**

5           “(a) FUND AGREEMENTS.—For the purpose de-  
6 scribed in subsection (b), the Secretary is authorized to  
7 enter into an agreement for the establishment and oper-  
8 ation of a student loan fund with any public or nonprofit  
9 school of medicine or osteopathic medicine.

10          “(b) PURPOSE.—The purpose of this subpart is to  
11 provide for loans to medical students who would be eligible  
12 for a loan under subpart II, except for the student’s deci-  
13 sion to enter a residency training program in a field other  
14 than primary health care.

15          “(c) COMMENCEMENT OF REPAYMENT PERIOD.—  
16 The repayment period for a loan under this section shall  
17 not begin before the end of any period during which the  
18 student is participating in an internship, residency, or fel-  
19 lowship training program directly related to the field of  
20 medicine which the student agrees to enter pursuant to  
21 subsection (d).

22          “(d) REQUIREMENTS FOR STUDENTS.—Each agree-  
23 ment under this section for the establishment of a student  
24 loan fund shall provide that the school of medicine or os-  
25 teopathic medicine will make a loan to a student from such  
26 fund only if the student agrees—

1           “(1) to enter and complete a residency training  
2           program (in a field of medicine other than primary  
3           health care) not later than a period determined by  
4           the Secretary to be reasonable after the date on  
5           which the student graduates from such school; and

6           “(2) to practice medicine through the date on  
7           which the loan is repaid in full.

8           “(e) REQUIREMENTS FOR SCHOOLS.—The provisions  
9           of section 723(b) (regarding graduates in primary health  
10          care) shall not apply to a student loan fund established  
11          under this section.

12          “(f) APPLICABILITY OF OTHER PROVISIONS.—Ex-  
13          cept as inconsistent with this section, the provisions of  
14          subpart II shall apply to the program of student loan  
15          funds established under this section to the same extent  
16          and in the same manner as such provisions apply to the  
17          program of student loan funds established under subpart  
18          II.

19          “(g) AUTHORIZATION OF APPROPRIATIONS.—To  
20          carry out this section, there are authorized to be appro-  
21          priated such sums as may be necessary for fiscal year  
22          2010 and each fiscal year thereafter.”.

1     **Subtitle B—Loan Forgiveness for**  
2             **Primary Care Providers**

3     **SEC. 1111. LOAN FORGIVENESS FOR PRIMARY CARE PRO-**  
4             **VIDERS.**

5             (a) IN GENERAL.—The Secretary of Health and  
6 Human Services shall carry out a program of entering into  
7 contracts with eligible individuals under which—

8                 (1) the individual agrees to serve for a period  
9 of not less than 5 years as a primary care provider;  
10 and

11                (2) in consideration of such service, the Sec-  
12 retary agrees to pay not more than \$50,000 on the  
13 principal and interest on the individual's graduate  
14 educational loans.

15             (b) ELIGIBILITY.—To be eligible to enter into a con-  
16 tract under subsection (a), an individual must—

17                (1) have a graduate degree in medicine, osteo-  
18 pathic medicine, or another health profession from  
19 an accredited (as determined by the Secretary of  
20 Health and Human Services) institution of higher  
21 education; and

22                (2) have practiced as a primary care provider  
23 for a period (excluding any residency or fellowship  
24 training period) of not less than—

25                         (A) 5 years; or

1 (B) 3 years in a medically underserved  
2 community (as defined in section 799B of the  
3 Public Health Service Act (42 U.S.C. 295p)).

4 (c) INSTALLMENTS.—Payments under this section  
5 may be made in installments of not more than \$10,000  
6 for each year of service described in subsection (a)(1).

7 (d) APPLICABILITY OF CERTAIN PROVISIONS.—The  
8 provisions of subpart III of part D of title III of the Public  
9 Health Service Act shall, except as inconsistent with this  
10 section, apply to the program established under this sec-  
11 tion in the same manner and to the same extent as such  
12 provisions apply to the National Health Service Corps  
13 Loan Repayment Program established in such subpart.

## 14 **TITLE XII—OFFSETS**

### 15 **Subtitle A—Enforcing**

### 16 **Discretionary Spending Limits**

17 **SEC. 1201. ENFORCING DISCRETIONARY SPENDING LIMITS.**

18 (a) DISCRETIONARY SPENDING LIMITS.—Sections  
19 251(b) and (c) of the Balanced Budget and Emergency  
20 Deficit Control of Act of 1985 are amended to read as  
21 follows:

22 “(b) DISCRETIONARY SPENDING LIMIT.—As used in  
23 this part, the term ‘discretionary spending limit’ means—

24 “(1) with respect to fiscal year 2010,  
25 \$1,173,000,000,000 in new budget authority of

1 which no more than \$481,140,000,000 shall be for  
2 the nondefense category;

3 “(2) with respect to fiscal year 2011,  
4 \$1,096,439,000,000 in new budget authority of  
5 which no more than \$476,329,000,000 shall be for  
6 the nondefense category;

7 “(3) with respect to fiscal year 2012,  
8 \$1,100,705,000 in new budget authority of which no  
9 more than \$471,565,000,000 shall be for the non-  
10 defense category;

11 “(4) with respect to fiscal year 2013,  
12 \$1,106,750,000,000 in new budget authority of  
13 which no more than \$466,850,000,000 shall be for  
14 the nondefense category;

15 “(5) with respect to fiscal year 2014,  
16 \$1,116,011,000,000 in new budget authority of  
17 which no more than \$462,181,000,000 shall be for  
18 the nondefense category;

19 “(6) with respect to fiscal year 2015,  
20 \$1,117,559,000,000 in new budget authority of  
21 which no more than \$457,559,000,000 shall be for  
22 the nondefense category;

23 “(7) with respect to fiscal year 2016,  
24 \$1,117,984,000,000 in new budget authority of

1 which no more than \$452,984,000,000 shall be for  
2 the nondefense category;

3 “(8) with respect to fiscal year 2017,  
4 \$1,118,454,000,000 in new budget authority of  
5 which no more than \$448,454,000,000 shall be for  
6 the nondefense category;

7 “(9) with respect to fiscal year 2018,  
8 \$1,118,969,000,000 in new budget authority of  
9 which no more than 443,969,000,000 shall be for  
10 the nondefense category; and

11 “(10) with respect to fiscal year 2019,  
12 \$1,127,530,000,000 in new budget authority of  
13 which no more than \$439,530,000,000 shall be for  
14 the nondefense category.”

15 (b) DISCRETIONARY SPENDING LIMIT POINT OF  
16 ORDER.—Section 312 of the Congressional Budget Act of  
17 1974 (as amended by section 214(a)) is further amended  
18 by adding at the end the following new subsection:

19 “(h) DISCRETIONARY SPENDING LIMIT POINT OF  
20 ORDER.—It shall not be in order in the House of Rep-  
21 resentatives or the Senate to consider any bill, joint resolu-  
22 tion, amendment, or conference report that—

23 “(1) increases the discretionary spending limits  
24 for any ensuing fiscal year after the budget year; or

1           “(2) would cause the discretionary spending  
2           limits for the budget year to be breached.”.

3           (c) ADVANCE APPROPRIATION POINT OF ORDER.—  
4           Section 312 of the Congressional Budget Act of 1974 (as  
5           amended by this section) is further amended by adding  
6           at the end the following new subsection:

7           “(i) ADVANCE APPROPRIATION POINT OF ORDER.—  
8           It shall not be in order in the House of Representatives  
9           or the Senate to consider any appropriation bill or joint  
10          resolution, or amendment thereto or conference report  
11          thereon, that provides advance discretionary new budget  
12          authority that first becomes available for any fiscal year  
13          after the budget year at an amount for any program,  
14          project, or activity above the amount of appropriations for  
15          fiscal year 2007 for such program, project, or activity.”.

## 16           **Subtitle B—Repeal of Unused** 17           **Stimulus Funds**

### 18          **SEC. 1211. RESCISSION AND REPEAL IN ARRA.**

19          (a) RESCISSION.—Of the discretionary appropria-  
20          tions made available in division A of the American Recov-  
21          ery and Reinvestment Act of 2009 (Public Law 111–5),  
22          all unobligated balances are rescinded.

23          (b) REPEAL.—Subtitles B and C of title II and titles  
24          III through VII of division B of the American Recovery

1 and Reinvestment Act of 2009 (Public Law 111–5) are  
2 repealed.

3 **Subtitle C—Savings From Health**  
4 **Care Efficiencies**

5 **SEC. 1221. MEDICARE DSH REPORT AND PAYMENT ADJUST-**  
6 **MENTS IN RESPONSE TO COVERAGE EXPAN-**  
7 **SION.**

8 (a) DSH REPORT.—

9 (1) IN GENERAL.—Not later than January 1,  
10 2014, the Secretary of Health and Human Services  
11 shall submit to Congress a report on Medicare DSH  
12 taking into account the impact of the health care re-  
13 forms carried out under this Act in reducing the  
14 number of uninsured individuals. The report shall  
15 include recommendations relating to the following:

16 (A) The appropriate amount, targeting,  
17 and distribution of Medicare DSH to com-  
18 pensate for higher Medicare costs associated  
19 with serving low-income beneficiaries (taking  
20 into account variations in the empirical jus-  
21 tification for Medicare DSH attributable to hos-  
22 pital characteristics, including bed size), con-  
23 sistent with the original intent of Medicare  
24 DSH.

1           (B) The appropriate amount, targeting,  
2           and distribution of Medicare DSH to hospitals  
3           given their continued uncompensated care costs,  
4           to the extent such costs remain.

5           (2) COORDINATION WITH MEDICAID DSH RE-  
6           PORT.—The Secretary shall coordinate the report  
7           under this subsection with the report on Medicaid  
8           DSH under section 1222(a).

9           (b) PAYMENT ADJUSTMENTS IN RESPONSE TO COV-  
10          ERAGE EXPANSION.—

11           (1) IN GENERAL.—If there is a significant de-  
12          crease in the national rate of uninsurance as a result  
13          of this Act (as determined under paragraph (2)(A)),  
14          then the Secretary of Health and Human Services  
15          shall, beginning in fiscal year 2015, implement the  
16          following adjustments to Medicare DSH:

17           (A) In lieu of the amount of Medicare  
18          DSH payment that would otherwise be made  
19          under section 1886(d)(5)(F) of the Social Secu-  
20          rity Act, the amount of Medicare DSH payment  
21          shall be an amount based on the recommenda-  
22          tions of the report under subsection (a)(1)(A)  
23          and shall take into account variations in the  
24          empirical justification for Medicare DSH attrib-

1           utable to hospital characteristics, including bed  
2           size.

3           (B) Subject to paragraph (3), make an ad-  
4           ditional payment to a hospital by an amount  
5           that is estimated based on the amount of un-  
6           compensated care provided by the hospital  
7           based on criteria for uncompensated care as de-  
8           termined by the Secretary, which shall exclude  
9           bad debt.

10          (2) SIGNIFICANT DECREASE IN NATIONAL RATE  
11          OF UNINSURANCE AS A RESULT OF THIS ACT.—For  
12          purposes of this subsection—

13               (A) IN GENERAL.—There is a “significant  
14               decrease in the national rate of uninsurance as  
15               a result of this Act” if there is a decrease in  
16               the national rate of uninsurance (as defined in  
17               subparagraph (B)) from 2010 to 2012 that ex-  
18               ceeds 8 percentage points.

19               (B) NATIONAL RATE OF UNINSURANCE  
20               DEFINED.—The term “national rate of  
21               uninsurance” means, for a year, such rate for  
22               the under-65 population for the year as deter-  
23               mined and published by the Bureau of the Cen-  
24               sus in its Current Population Survey in or  
25               about September of the succeeding year.

1 (3) UNCOMPENSATED CARE INCREASE.—

2 (A) COMPUTATION OF DSH SAVINGS.—For  
3 each fiscal year (beginning with fiscal year  
4 2015), the Secretary shall estimate the aggregate  
5 reduction in Medicare DSH that will result  
6 from the adjustment under paragraph (1)(A).

7 (B) STRUCTURE OF PAYMENT IN-  
8 CREASE.—The Secretary shall compute the in-  
9 crease in Medicare DSH under paragraph  
10 (1)(B) for a fiscal year in accordance with a  
11 formula established by the Secretary that pro-  
12 vides that—

13 (i) the aggregate amount of such in-  
14 crease for the fiscal year does not exceed  
15 50 percent of the aggregate reduction in  
16 Medicare DSH estimated by the Secretary  
17 for such fiscal year; and

18 (ii) hospitals with higher levels of un-  
19 compensated care receive a greater in-  
20 crease.

21 (c) MEDICARE DSH.—In this section, the term  
22 “Medicare DSH” means adjustments in payments under  
23 section 1886(d)(5)(F) of the Social Security Act (42  
24 U.S.C. 1395ww(d)(5)(F)) for inpatient hospital services  
25 furnished by disproportionate share hospitals.

1 **SEC. 1222. REDUCTION IN MEDICAID DSH.**

2 (a) REPORT.—

3 (1) IN GENERAL.—Not later than January 1,  
4 2014, the Secretary of Health and Human Services  
5 (in this title referred to as the “Secretary”) shall  
6 submit to Congress a report concerning the extent to  
7 which, based upon the impact of the health care re-  
8 forms carried out under this Act in reducing the  
9 number of uninsured individuals, there is a contin-  
10 ued role for Medicaid DSH. In preparing the report,  
11 the Secretary shall consult with community-based  
12 health care networks serving low-income bene-  
13 ficiaries.

14 (2) MATTERS TO BE INCLUDED.—The report  
15 shall include the following:

16 (A) RECOMMENDATIONS.—Recommendations regarding—

17 (i) the appropriate targeting of Medicaid DSH within States; and

18 (ii) the distribution of Medicaid DSH among the States.

19 (B) SPECIFICATION OF DSH HEALTH REFORM METHODOLOGY.—The DSH Health Reform methodology described in paragraph (2) of subsection (b) for purposes of implementing the requirements of such subsection.

1           (3) COORDINATION WITH MEDICARE DSH RE-  
2           PORT.—The Secretary shall coordinate the report  
3           under this subsection with the report on Medicare  
4           DSH under section 1221.

5           (4) MEDICAID DSH.—In this section, the term  
6           “Medicaid DSH” means adjustments in payments  
7           under section 1923 of the Social Security Act for in-  
8           patient hospital services furnished by dispropor-  
9           tionate share hospitals.

10          (b) MEDICAID DSH REDUCTIONS.—

11           (1) IN GENERAL.—If there is a significant de-  
12           crease in the national rate of uninsurance as a result  
13           of this Act (as determined under section  
14           1221(a)(2)(A)), then the Secretary of Health and  
15           Human Services shall reduce Medicaid DSH so as to  
16           reduce total Federal payments to all States for such  
17           purpose by \$1,500,000,000 in fiscal year 2015,  
18           \$2,500,000,000 in fiscal year 2016, and  
19           \$6,000,000,000 in fiscal year 2017.

20           (2) DSH HEALTH REFORM METHODOLOGY.—  
21           The Secretary shall carry out paragraph (1) through  
22           use of a DSH Health Reform methodology issued by  
23           the Secretary that imposes the largest percentage re-  
24           ductions on the States that—

1 (A) have the lowest percentages of unin-  
2 sured individuals (determined on the basis of  
3 audited hospital cost reports) during the most  
4 recent year for which such data are available;  
5 or

6 (B) do not target their DSH payments  
7 on—

8 (i) hospitals with high volumes of  
9 Medicaid inpatients (as defined in section  
10 1923(b)(1)(A) of the Social Security Act  
11 (42 U.S.C. 1396r-4(b)(1)(A)); and

12 (ii) hospitals that have high levels of  
13 uncompensated care (excluding bad debt).

14 (3) DSH ALLOTMENT PUBLICATIONS.—

15 (A) IN GENERAL.—Not later than the pub-  
16 lication deadline specified in subparagraph (B),  
17 the Secretary shall publish in the Federal Reg-  
18 ister a notice specifying the DSH allotment to  
19 each State under 1923(f) of the Social Security  
20 Act for the respective fiscal year specified in  
21 such subparagraph, consistent with the applica-  
22 tion of the DSH Health Reform methodology  
23 described in paragraph (2).

1 (B) PUBLICATION DEADLINE.—The publi-  
2 cation deadline specified in this subparagraph  
3 is—

4 (i) January 1, 2014, with respect to  
5 DSH allotments described in subparagraph  
6 (A) for fiscal year 2015;

7 (ii) January 1, 2015, with respect to  
8 DSH allotments described in subparagraph  
9 (A) for fiscal year 2016; and

10 (iii) January 1, 2016, with respect to  
11 DSH allotments described in subparagraph  
12 (A) for fiscal year 2017.

13 (c) CONFORMING AMENDMENTS.—

14 (1) Section 1923(f) of the Social Security Act  
15 (42 U.S.C. 1396r–4(f)) is amended—

16 (A) by redesignating paragraph (7) as  
17 paragraph (8); and

18 (B) by inserting after paragraph (6) the  
19 following new paragraph:

20 “(7) SPECIAL RULE FOR FISCAL YEARS 2015,  
21 2016, AND 2017.—Notwithstanding paragraph (2), if  
22 the Secretary makes a reduction under section  
23 1222(b)(1) of the Siding with America’s Patients  
24 Act, the total DSH allotments for all States for—

1           “(A) fiscal year 2015, shall be the total  
2           DSH allotments that would otherwise be deter-  
3           mined under this subsection for such fiscal year  
4           decreased by \$1,500,000,000;

5           “(B) fiscal year 2016, shall be the total  
6           DSH allotments that would otherwise be deter-  
7           mined under this subsection for such fiscal year  
8           decreased by \$2,500,000,000; and

9           “(C) fiscal year 2017, shall be the total  
10          DSH allotments that would otherwise be deter-  
11          mined under this subsection for such fiscal year  
12          decreased by \$6,000,000,000.”.

13          (2) Section 1923(b)(4) of such Act (42 U.S.C.  
14          1396r-4(b)(4)) is amended by adding before the pe-  
15          riod the following: “or to affect the authority of the  
16          Secretary to issue and implement the DSH Health  
17          Reform methodology under section 1704(b)(2) of the  
18          Siding with America’s Patients Act”.

19          (d) DISPROPORTIONATE SHARE HOSPITALS (DSH)  
20          AND ESSENTIAL ACCESS HOSPITAL (EAH) NON-DIS-  
21          CRIMINATION.—

22          (1) IN GENERAL.—Section 1923(d) of the So-  
23          cial Security Act (42 U.S.C. 1396r-4) is amended  
24          by adding at the end the following new paragraph:

1           “(4) No hospital may be defined or deemed as  
2           a disproportionate share hospital, or as an essential  
3           access hospital (for purposes of subsection  
4           (f)(6)(A)(iv), under a State plan under this title or  
5           subsection (b) of this section (including any waiver  
6           under section 1115) unless the hospital—

7                   “(A) provides services to beneficiaries  
8                   under this title without discrimination on the  
9                   ground of race, color, national origin, creed,  
10                  source of payment, status as a beneficiary  
11                  under this title, or any other ground unrelated  
12                  to such beneficiary’s need for the services or the  
13                  availability of the needed services in the hos-  
14                  pital; and

15                  “(B) makes arrangements for, and accepts,  
16                  reimbursement under this title for services pro-  
17                  vided to eligible beneficiaries under this title.”.

18           (2) EFFECTIVE DATE.—The amendment made  
19           by subsection (a) shall be apply to expenditures  
20           made on or after July 1, 2010.

1           **Subtitle D—Fraud, Waste, and**  
2                           **Abuse**

3   **SEC. 1231. PROVIDE ADEQUATE FUNDING TO HHS OIG AND**  
4                           **HCFAC.**

5           (a) HCFAC FUNDING.—Section 1817(k)(3)(A) of  
6 the Social Security Act (42 U.S.C. 1395i(k)(3)(A)) is  
7 amended—

8                   (1) in clause (i)—

9                           (A) in subclause (IV), by striking “2009,  
10 and 2010” and inserting “and 2009”; and

11                           (B) by amending subclause (V) to read as  
12 follows:

13   “(V) for each fiscal year after fis-  
14 cal year 2009, \$300,000,000.”; and

15                   (2) in clause (ii)—

16                           (A) in subclause (IX), by striking “2009,  
17 and 2010” and inserting “and 2009”; and

18                           (B) in subclause (X), by striking “2010”  
19 and inserting “2009” and by inserting before  
20 the period at the end the following: “, plus the  
21 amount by which the amount made available  
22 under clause (i)(V) for fiscal year 2010 exceeds  
23 the amount made available under clause (i)(IV)  
24 for 2009”.

1 (b) **OIG FUNDING.**—There are authorized to be ap-  
2 propriated for each of fiscal years 2010 through 2019  
3 \$100,000,000 for the Office of the Inspector General of  
4 the Department of Health and Human Services for fraud  
5 prevention activities under the Medicare and Medicaid  
6 programs.

7 **SEC. 1232. IMPROVED ENFORCEMENT OF THE MEDICARE**  
8 **SECONDARY PAYOR PROVISIONS.**

9 (a) **IN GENERAL.**—The Secretary, in coordination  
10 with the Inspector General of the Department of Health  
11 and Human Services, shall provide through the Coordina-  
12 tion of Benefits Contractor for the identification of in-  
13 stances where the Medicare program should be, but is not,  
14 acting as a secondary payer to an individual's private  
15 health benefits coverage under section 1862(b) of the So-  
16 cial Security Act (42 U.S.C. 1395y(b)).

17 (b) **UPDATING PROCEDURES.**—The Secretary shall  
18 update procedures for identifying and resolving credit bal-  
19 ance situations which occur under the Medicare program  
20 when payment under such title and from other health ben-  
21 efit plans exceed the providers' charges or the allowed  
22 amount.

23 (c) **REPORT ON IMPROVED ENFORCEMENT.**—Not  
24 later than 1 year after the date of the enactment of this  
25 Act, the Secretary shall submit a report to Congress on

1 progress made in improved enforcement of the Medicare  
2 secondary payor provisions, including recoupment of credit  
3 balances.

4 **SEC. 1233. STRENGTHEN MEDICARE PROVIDER ENROLL-**  
5 **MENT STANDARDS AND SAFEGUARDS.**

6 (a) STRENGTHENING MEDICARE PROVIDER NUM-  
7 BERS.—

8 (1) SCREENING NEW PROVIDERS.—As a condi-  
9 tion of a provider of services or a supplier, including  
10 durable medical equipment suppliers and home  
11 health agencies, applying for the first time for a pro-  
12 vider number under the Medicare program and be-  
13 fore granting billing privileges under such title, the  
14 Secretary shall screen the provider or supplier for a  
15 criminal background or other financial or oper-  
16 ational irregularities through fingerprinting, licen-  
17 sure checks, site-visits, other 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

1       such a number, the Secretary shall provide enhanced  
2       oversight of the activities of such provider or sup-  
3       plier under the Medicare program, such as through  
4       prepayment review and payment limitations.

5           (4) PENALTIES FOR FALSE STATEMENTS.—In  
6       the case of a provider or supplier that knowingly  
7       makes a false statement in an application for such  
8       a number, the Secretary may exclude the provider or  
9       supplier from participation under the Medicare pro-  
10      gram, or may impose a civil money penalty (in the  
11      amount described in section 1128A(a)(4) of the So-  
12      cial Security Act) , in the same manner as the Sec-  
13      retary may impose such an exclusion or penalty  
14      under sections 1128 and 1128A, respectively, of  
15      such Act in the case of knowing presentation of a  
16      false claim described in section 1128A(a)(1)(A) of  
17      such Act.

18           (5) DISCLOSURE REQUIREMENTS.—With re-  
19      spect to approval of such an application, the Sec-  
20      retary—

21           (A) shall require applicants to disclose pre-  
22      vious affiliation with enrolled entities that have  
23      uncollected debt related to the Medicare or  
24      Medicaid programs;

1 (B) may deny approval if the Secretary de-  
2 termines that these affiliations pose undue risk  
3 to the Medicare or Medicaid program, subject  
4 to an appeals process for the applicant as deter-  
5 mined by the Secretary; and

6 (C) may implement enhanced safeguards  
7 (such as surety bonds).

8 (b) MORATORIA.—The Secretary may impose mora-  
9 toria on approval of provider and supplier numbers under  
10 the Medicare program for new providers of services and  
11 suppliers as determined necessary to prevent or combat  
12 fraud a period of delay for any one applicant cannot ex-  
13 ceed 30 days unless cause is shown by the Secretary.

14 (c) FUNDING.—There are authorized to be appro-  
15 priated to carry out this section such sums as may be nec-  
16 essary.

17 **SEC. 1234. TRACKING BANNED PROVIDERS ACROSS STATE**  
18 **LINES.**

19 (a) GREATER COORDINATION.—The Secretary shall  
20 provide for increased coordination between the Adminis-  
21 trator of the Centers for Medicare & Medicaid Services  
22 (in this section referred to as “CMS”) and its regional  
23 offices to ensure that providers of services and suppliers  
24 that have operated in one State and are excluded from  
25 participation in the Medicare program are unable to begin

1 operation and participation in the Medicare program in  
2 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.

8 **SEC. 1235. REINSTATE THE MEDICARE TRIGGER.**

9 Section 3 of House Resolution 5 of the One Hundred  
10 Eleventh Congress is amended by striking subsection (e)  
11 (relating to Medicare cost containment).